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ABSTRACT

The processes whereby nurses develop the skills and knowledge required to deliver individualized and holistic care were examined in a 2-year study of nurses in a range of clinical settings and a university department of nursing in England. Members of two research teams of qualified nurses joined various communities of nursing practice as participating members and simultaneously "shadowed" designated nurses. At day's end, shadowers and shadowees reviewed the day's practice in critical incident interviews. The powerful processes of nurse socialization that create a strong core identity of the "good nurse" proved central to understanding the acquisition, use, and protection of nursing skills. Learning to become a nurse was always situated within particular communities of practice. Learning in such contexts, both in clinical and educational settings, entailed not just mastering a range of intellectual concepts but also learning through embodied performances involving engagement and interaction with the community of practice. The following were among the study recommendations: (1) link educational and clinical settings by helping clinical staff understand their collective role in the educational experience; (2) enhance the mentor and assessor functions; and (3) enable, support, and resource time in education for clinicians and time in practice for educators. (Contains 87 references.) (MN)

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Nurse Education and Communities of Practice

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English National Board for Nursing, Midwifery and Health Visiting

RESEARCHING PROFESSIONAL EDUCATION

A series from the English National Board for Nursing, Midwifery and Health Visiting

Nurse Education and Communities of Practice

Ian Burkitt
Charles Husband
Jennifer Mackenzie
Alison Torn
with Rosemary Crow

London, 2001

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The Steering Group

Rosemary Crow, University of Surrey

Sonia Crow, Assistant Director for Educational Policy (R&D),
English National Board for Nursing, Midwifery and Health Visiting

Colin Lago, University of Sheffield

Cathy Renouf, Education Officer, English National Board for Nursing, Midwifery and Health Visiting

Ian Stronach, Manchester Metropolitan University *(Chair)*

Anne Williams, University of Swansea

The Authors

Ian Burkitt is a Senior Lecturer in Sociology and Social Psychology in the Department of Applied Social Sciences, University of Bradford. His main research interests include self and embodiment, and social and psychological theory. Ian is the author of *Social Selves: Theories of the Social Formation of Personality* (Sage, 1991) and *Bodies of Thought: Embodiment, Identity and Modernity* (Sage, 1999).

Charles Husband is Professor of Social Analysis and Director of the Ethnicity and Social Policy Research Unit at the University of Bradford. He has published widely on issues of health and social care and is co-author of *Nursing for a Multi-Ethnic Society* (Open University Press, 1996), and co-author of the Open University book series on *Race, Health and Social Care.*

Jennifer Mackenzie is Senior Lecturer at the School of Health Studies, University of Bradford, where she has a remit for multidisciplinary and multiprofessional research. She has held various clinical posts in nursing since 1977 and moved into education and research in 1989. Since then Jennifer has been engaged in research in nurse education and practice and is co-author of *Nursing for a Multi-Ethnic Society* (Open University, 1996), editor of *Ward Management in Practice* (Churchill Livingstone, 1998) and Assistant Editor of the *Journal of Clinical Nursing* (Blackwell).

Alison Torn is Research Fellow at Bradford University. Her clinical nursing career was in mental health and substance misuse. She previously researched the nurse practitioner role and its potential utility in mental health. In collaboration with a psycho-geriatrician she has studied the determining psychological factors that affect the outcome of elderly hip fracture patients. Currently, she is involved with the Bradford Health Action Zone evaluation exercise.

Rosemary Crow is Professor of Nursing Sciences at the University of Surrey and Visiting Professor at City University Dublin. She has an internationally recognised expertise in clinical judgement and has a special interest in nurses' judgement.

Abbreviations

A&E	Accident and emergency
AP(E)L	Accreditation of prior (experiential) learning
CFP	Common foundation programme
CMHT	Community mental health team
CPN	Community psychiatric nurse
ECG	Electrocardiogram
GNC	General Nursing Council
HEFCE	Higher Education Funding Council for England
NHS	National Health Service
QAA	Quality Assurance Agency for Higher Education
RAE	Research Assessment Exercise
RCN	Royal College of Nursing
SEN	State enrolled nurse
SRN	State registered nurse
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
VAD	Voluntary Aid detachment

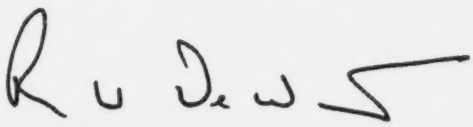
Foreword

The English National Board for Nursing, Midwifery and Health Visiting is delighted to publish this report as the eighteenth in its successful series: *Researching Professional Education.*

The Board launched this series with the aim of making widely available the results and implications of research commissioned by the Board. The series enables key stakeholders: policy makers, managers, practitioners, researchers and educators to have access to relevant and sound research from which to plan educational developments.

Learning to become a nurse is always situated within particular communities of practice. Becoming a nurse involves more than the learning of a body of knowledge and a range of skills. It involves a complex process of socialisation to develop a professional whose very identity is constructed and maintained within nursing practice.

This research is a valuable aid to our understanding of the emotional and intellectual process of learning within practice.



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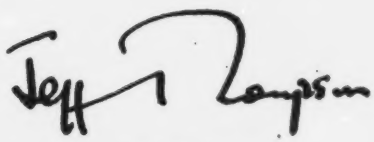

Professor Jeff Thompson
Chair, Research and Development Committee, English National Board for Nursing, Midwifery and Health Visiting

London, 2001

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1.1 Difficulties in categorising the knowledge and skills of practising nurses

This project, which was commissioned by the English National Board for Nursing, Midwifery and Health Visiting (the Board), began as an evaluation of the cognitive and affective processes in the educational preparation for individualised and holistic care, but became something slightly different. The research was begun with some trepidation; there is a wide ranging debate within the social sciences generally, and nursing in particular, as to the effectiveness of considering cognitive and affective processes as distinct entities. Given this debate and the emphasis on the embodied practitioner in some nursing literature, the researchers wondered whether it would be possible to neatly categorise the knowledge and skills employed by practising nurses as belonging to either the cognitive or affective realms. If not, it would be impossible to draw cognitive or affective implications from the research for the educational preparation of nurses for individualised and holistic care.

These concerns were based in theoretical knowledge drawn from the researchers' respective academic fields, but were made concrete as pilot focus group interviews began. In these groups both students and qualified nurses were asked about the terms cognition and affect and how they used these terms in their practice, or retrospectively, to make sense of their practice. Instead of a lively debate developing about the usefulness of these terms or considered deliberation on the cognitive and affective processes employed in nursing, there was bemusement: these were terms that nurses neither frequently used nor understood in any detail. While most realised that 'cognition' had something to do with thought processes, few had any understanding of 'affect', frequently confusing it with the other term relating to the effects of one's actions. This continued throughout the research in all fields in which nursing practice and education were studied. In the educational setting there was greater awareness of the terms, and some tutors made an effort to get students to deliberate on them in order to better reflect upon and understand their practice. However, such tutors were a small minority. In the school of health where the educational part of the research was conducted, most tutors were as vague about the terms as practitioners, with some claiming that if cognition was mentioned at all it would be in the psychology module and not in any nursing modules. This invariably turned out to be the case.

As an ethnographic style of research had been adopted, on the grounds that the researchers wanted to try to understand how knowledge and skill in nursing actually develop through education and practice, this caused a dilemma. Should a set of terms be imposed upon nurses and educators that made no sense to them, or should a new set of concepts be sought that seemed to explain what appeared to be emerging from the data and which nurses and educators were more comfortable with? The latter option was chosen. Indeed, the whole aim of ethnographic research is to allow the voices of those being studied to come through and to enter into dialogue with the researchers. The project's aim was to find out what nurses and educators thought was important knowledge and skill in nursing practice and education, rather than to impose on them terminology or concepts they found alien.

1.2 The structure of the report

Chapters 3 and 4 detail how the emerging concepts, such as 'community of practice' (Lave and Wenger, 1991), were used and developed. The way the researchers worked is described as a dialectical approach to both theory and ethnographic research, because concepts were only used that helped both the researchers and those being studied understand nursing practice and education. The concept of community of practice also helped the researchers to understand

how the learning of nursing skills and the development of a body of knowledge about nursing is a practical as well as an intellectual process. Nurses learn as much about nursing through participation in joint practices with more experienced nurses as from the more abstract book and lecture style of learning found in the school of nursing. Furthermore, when nurses are engaged in the practical delivery of care, they are engaged at all levels of their being: they are thinking in terms of theories they have learned, research they have read about and their own experiences in caring for patients. Yet at the same time, they are feeling various emotions about patients with whom they have built up some relationship, and sensing things from this about the patient's condition and the possible options for their care. The nurses may be only vaguely aware of these things, yet all these levels of awareness and skill will come into play in the delivery of care. In such situations that the researchers observed and talked about with nurses, it would be impossible to say at any one time whether the processes involved in the delivery of individualised and holistic care were cognitive or affective. They are both present simultaneously, and the task has been to understand how these processes work in unison. What emerges from Chapters 7 and 8, where the clinical data are analysed, is a consideration of cognitive and affective processes, but through a framework which does not attempt to see these processes as separable and confinable, but integral and working in unison.

The way in which the question of cognition and affect was conceptualised is outlined in Chapter 4, and the data presented in later chapters show that this is a sustainable and intelligible position. The change of emphasis in this report happened not only in the process of data collection and interpretation, nor solely in theoretical reflection upon this process, but also in close dialogue with the steering committee and through a symposium of practitioners in the early days of the research. The symposium, in January 1998, was held to see if the emerging change in the interpretative framework made sense to leading figures in nursing practice, education and health care delivery. Not only did they find the concept of communities of practice illuminating, those involved also confirmed the importance of nurse socialisation.

The aim of the research therefore became not simply to study the learning of skills, whether cognitive or affective, but rather to try to trace the construction of an identity – the professional nurse – and the role of education and practice placements in professional socialisation. The skills and knowledge that nurses learn in their education are elements in a wider process – the formation of a professional nursing identity within communities of nursing practice. Cognitive and affective processes must be seen in this context in order to be properly understood.

However, before the discussion of the concept of communities of practice begins, Professor Rosemary Crow sets the scene in Chapter 2 with an overview of some recent changes in nursing practice and education, including the development of Project 2000 and the movement of nurse education into higher education. Chapter 3 gives an overview of the methodology used in this study and details the research sites selected, along with sample sizes.

Chapter 4 outlines the core concepts of power relations, communities of practice, emotions and embodiment. It is argued that nursing can be seen as a community of practice which sustains relations between nurses and also relations to other communities of practice such as doctors, social workers and other professions allied to medicine. The community of practice in nursing also socialises new members into its ranks, who pass from the periphery of practice as students to more central positions as they take more responsibility for practice and gradually construct the identity of a professional nurse. However, this involves micro-political relations between and within communities of practice: in this case, between nurses and other professionals, and within nursing itself between the different grades and between qualified and unqualified practitioners.

It is also argued that nursing and situated learning involves more than just the cognitive apprehension of knowledge. Instead, it is seen as based in the mastery of practice and the gradual building of intuitive knowing – embodied knowledge that incorporates body consciousness, practical consciousness, emotion and experience. It is emotion that often accounts

for the lightening-quick reactions in clinical decision-making, and is generally labelled 'intuition'. All this, along with the conscious levels of knowledge that nurses employ, is highly dependent on the time/space context in which nursing practice is embedded.

These ideas are taken further in Chapter 5, where the concepts of communities of practice, situated learning, and the construction of professional identity are fleshed out with examples from participant observation and critical incident interviews. The researchers observed and talked about everyday nursing practice in a variety of contexts, and shadowed student nurses becoming members of the community of practice. This chapter takes the researchers' central concepts and illuminates them in the context of clinical practice through a close examination of a range of practice sites. This comparative exploration of the situated delivery of nursing care opens up an understanding of nurse socialisation as developing a common core professional identity as nurse – delivering holistic individualised care – alongside specialist nursing identities grounded in the specific context of nursing care delivery. The tension between the ideal aspirations of this core identity and the community of practice, as a constraint upon this practical expression, is revealed as a powerful factor in shaping nursing careers.

Chapter 6 explores data derived from interviews with staff and students in a large school of nursing. The different place of pre-registration and post-registration education in nursing is immediately revealed; the former essentially laying down the initial fabric of the core 'nurse' identity and the latter facilitating the ongoing negotiation of this in relation to career choices that have shaped specialist identities. The dynamics of the educational institution again reveal the role of physical and social constraints, within institutional differentials of power between participants, as constructing communities of practice that reproduce nursing identities. The traditional concern with the theory/practice dynamic in nursing education is revealed as existing as a shared agenda between the educational and clinical settings, where the specific stresses of each community of practice uniquely inflects this discourse.

The following two chapters revolve around the analysis of the clinical data, drawn from participant observation and critical incident interviews in a variety of clinical settings. Chapter 7 focuses on the stresses involved in nursing, where practitioners must adapt to the speed-up in labour time and the demands for greater flexibility. The 'emotion work' involved in nursing and the pressures of increasing demands for the management of emotion in a variety of different contexts are examined. The performance and management of emotion is therefore highly time/space dependent and contextualised. However, the way emotion is used to bind the community of practice and thus becomes an element in the construction of nurses' identity is noted. In particular, humour is used in these ways – especially 'gallows humour' – defining the nursing community and nurse identity. But humour is also used to defuse potentially embarrassing situations and as a defence mechanism when nurses fear becoming overwhelmed by their emotions. Other coping strategies are examined, along with how many of these are individualised and expected to take place outside of the work setting, while others become virtually ritualised as key markers of membership in a specialised work culture.

Chapter 8 draws on the research data to examine the notion of clinical judgement, embodied learning and intuition. It is argued that the learning and practice of clinical decision-making skills does not always take place on the fully conscious or cognitive level. Rather, it often involves routine practices embedded in the community, and intuitive judgements involving body consciousness, emotion and practical experience that is never fully articulated into a rationalised, cognitive system of knowledge. Much clinical judgement is therefore based on intuition and this concept is explored through the research findings. The way student nurses begin to learn such judgement, through embodied learning (or performance based learning) within the community of practice is also examined. By linking personal judgement to the specific structural constraints of the workplace and the related distinctive culture of the community of practice, it becomes possible to see how professional competence may not be the same as professional performance. The community of practice may facilitate or inhibit the expression of personal professional competence.

One of the main themes to come out of this study, reflected in all chapters and in the conclusions and implications, is that of fragmentation and the way nurses are having to develop skills to cope with this. While fragmentation of experience in both clinical and educational settings may not pose a great threat to individualised care, it certainly poses a threat to holism. One of the paradoxes constantly found in this research is that while nurses are encouraged to take a holistic view of patients, no-one considers the nurse in a holistic way. Instead, nurses are often assumed to be individualised figures, divorced from the power relations and communities of practice in which they nurse, whose skills can be demarcated as either cognitive or affective. The researchers have tried to show that the nurse and his or her practice cannot be separated from the context of power relations, joint practices and institutional settings in which nursing takes place. However, these settings are becoming increasingly fragmented because of the rationalisation of health care organisations due to fiscal crises and increased monitoring of resources.

Health reforms since the late 1980s have created pressures in which nurses' labour must be used more effectively and flexibly. Nurses have adapted to more advanced practice and team management, becoming more effective managers of patient care and more effective in communication with patients and relatives. This requires them to become skilled in managing emotions – their own as well as those of patients and their significant others. Consequently the whole temporal and spatial organisation of nursing is changing and nurses are under pressure to be even more flexible in their working practices. In education a similar rationalisation is going on with the reorganisation of programmes of education, increased choice and flexibility, and the fragmentation of the system due to modularisation and semesterisation. The development of Project 2000 and the movement of nursing into higher education have significantly changed its context and organisation.

Given this situation, the conclusions and implications dwell on what educators and practice settings need to focus upon in order to prepare nurses who are fit for practice.

PRE-REGISTRATION EDUCATION: A FRAMEWORK FOR THE PROJECT ANALYSIS

2.1 Introduction

In order to evaluate the results from the study it was decided to generate an ideal approach to pre-registration nurse education. This was achieved by first seeking out factors that had influenced the development of nurse education. The review covers the period from the late 19th to the latter part of the 20th century, and its aim was to identify issues that had a significant effect on developments during this period. The lessons that emerged, together with matters pertinent to pre-registration education in the 21st century were brought together under the umbrella of an educational framework. The chapter closes with the creation of an ideal approach to pre-registration education based on the major implications arising from the review and the pertinent recommendations drawn from the recent Government and Regulatory body's reports.

2.2 Historical review of the development of pre-registration nurse education

The story of nurse education starts in 1860 with the introduction of two forms of training. Designed for the London hospitals, these provided a different route for those recruited to become nurse managers from those recruited to look after patients (Baly, 1973). Nurse training was principally concerned with domestic duties since the recruits were to be largely responsible for patients' hygiene and the neatness and cleanliness of the institution. The training programmes for matrons, on the other hand, were designed to put in place the Nightingale reforms (Baly, 1973). However the policy sparked off a struggle for control over training and practice that delayed the development of nurse education. The problem lay in the fact that the regulatory functions envisaged for matrons were in the hands of medical staff and hospital administrators, a situation that needed skilled handling. Unfortunately this did not occur and, as a consequence, the matrons' entitlement to regulate nurse training and practice was obstructed.

Significant developments came in the early 20th century when nursing had come to be regarded as a reputable occupation for women (Bendall and Raybould, 1969). Voluntary hospitals now recognised the advantage of employing trained nurses and matrons (Abel-Smith, 1979). A three-year training programme was introduced with hospital matrons regulating standards (Baly, 1973), and established a tradition to last well into the century in which nurse training schools became attached to hospitals. The hospitals employed trainees in an apprenticeship model, preparing them for the work they were to undertake. Around this time the General Nursing Council (GNC) was set up, following the Nurse Registration Act in 1919, and introduced nurse registration (SRN), state examinations and a syllabus with training guidelines. Registration imposed entry criteria, one portal of entry, and a professional code of conduct.

Once a national training system was recognised, the curriculum developed a more coherent structure, although its content was largely devoted to the study of medicine, surgery, and gynaecology. Taught by doctors, it involved brief descriptions of disease processes, signs, symptoms and medical treatment. Basic science was included, but at an elementary level (bacteriology, sanitation and hygiene), together with essential anatomy and physiology, food values, invalid cookery and first aid. Theoretical and practical nursing encompassed principles and practice of the procedures nurses carried out on the ward accompanied by practical training such as recording vital signs, wound care, drug administration, management of medical devices, and infection control (Bendall and Raybould, 1969). Taught by nurses, these were tasks that supported medical diagnostic and treatment regimens.

Preparing nurses was, therefore, little more than elaborate training in how to safely carry out doctors' orders, portraying nursing as a task-orientated practice. It certainly could not be described as education, since learning was by rote and any challenge to conventional wisdom frowned upon. Nor was it really nurse training as the content was medically orientated; there was little attempt to establish nursing as a discipline and no attempt to define the role of the nurse. Registered nurses were thus ill prepared to question their own practice, solve nursing problems or handle change. This meant that as the demands for health care grew, nurses did not have a clear vision of nursing's specific contribution to health care. They responded to medically-led developments, particularly those involving advancements in specialised investigations and treatments (Bevis, 1982).

After the First World War there was an expansion in the number of hospitals so that by 1930 there was a nursing shortage. *The Lancet*, in an attempt to improve nurses' education and working conditions, undertook a review of nurse education; in 1932 it proposed that nurses should be examined on nursing issues. For the first time a body of experts acknowledged that nurses' needed their own knowledge base. It was not to be. The GNC considered the commission had discussed *'questions of policy outside its terms of reference'* (Bendall and Raybould 1969: 100). Subsequent reports by Wood (MoH et al., 1947) Platt (RCN, 1964) and Briggs (DHSS, 1972), commissioned for similar reasons contained a range of recommendations that also favoured an 'educational' rather than 'training' approach to the preparation of nurses. The Wood report (MoH et al., 1947) recommended that trainee nurses be given full student status, domestic duties be removed and training be reduced from three to two years to give a year of supervision after qualification. There was also a proposal that teaching staff needed to be trained in modern educational techniques and students should be under the control of a training authority not the hospital (MoH et al., 1947: paragraphs 146-149). Hospital matrons, who dominated the GNC and the Royal College of Nursing (RCN), opposed any proposal that appeared to undermine their position. Only some of the recommendations were therefore integrated into training, leaving hospital matrons in charge of nurse training and the apprenticeship system intact (Clay, 1987).

The subsequent Platt (1964) and Briggs (1972) reports again recommended that nurses in training should be given student status, but to no avail.

The professional image of the nurse, to which the insistence on a preparation that represented training rather than education contributed, compromised the status of nursing. The Voluntary Aid detachment (VAD) scheme confused the picture. As a second gate of entry it was introduced to meet the shortage in nurses after the Second World War. The problem of recruitment prompted an agreement in 1943 that these 'assistant nurses' should have their names entered onto a 'Roll', enabling them to become State Enrolled Nurses (SENs). However, recruits who chose SEN enrolment came to be seen as second best by State Registered Nurses (SRNs), fostering a sense of elitism. Consequently, SRNs became associated with administration, while SENs took responsibility for practical care, perpetuating the separation in training between those who managed and those who worked at the bedside that was introduced in Nightingale's day.

The failure of attempts to lift pre-registration nurse training to the status of an education were not solely due to opposition from nurse managers. There was (and continues to be in some quarters both within and outside the profession) a suspicion of education supported by an assumption that people who 'shine academically' do not make competent practitioners. It took a small group of pioneers to move thinking forward by establishing a foothold in the university sector that enabled them to set in motion a tradition where the nature of nursing is subjected to systematic philosophical and empirical analysis. This early attempt to build a knowledge base for nursing coincided with the development of theoretically-generated nursing models (e.g. Roy and Robert, 1981; Orem, 1995) and the nursing process (Yura and Walsh, 1988) by nursing theorists in the USA. There followed a period of intense philosophical analysis of concepts thought to apply to nursing such as 'caring' (e.g. Leninger, 1981; Roach, 1984;

Benner and Wrubel, 1989), 'holism' 'individualised care' and 'health'. The growing literature provided a framework that focused on nursing issues creating a learning environment in which students were encouraged to question. The degree nursing programmes of education had thus moved away from the medical model that dominated traditional training and, in retrospect, illustrated the wisdom of *The Lancet*, Wood, Platt and Briggs committees. Life was not easy for those running university programmes; they faced considerable opposition from within the profession, while obtaining the right for degree students to register and securing validation of programmes from the GNC was a struggle. In addition, there was difficulty in obtaining training placements, particularly when the requests added to the demands placed on clinical areas by the traditional training programmes. There was also a period when students had to contend with a hostile reception from hospital staff who did not understand their needs. Nevertheless, ideas about the nature of nursing gradually went beyond the university walls, and nursing concepts slowly entered the curricula of traditional nursing schools; their inclusion became part of the standard requirements for nurse education through their adoption by the English National Board for Nursing, Midwifery and Health Visiting (the Board), which replaced the GNC in the early 1980s.

A series of reports in the first half of the 1980s closes this brief historical analysis of pre-registration nursing education. Dolan (1993) identified three factors that prompted the final shift for educational reform:

- demographic changes in the form of an expected shortfall of young people eligible to enter nursing in the 1980s, following a 35% drop in birth rate between 1964 and 1976
- a shift in emphasis from hospital-based illness interventions to community-based illness prevention
- a drive for cost-effectiveness and value for money, with the Government envisaging a course that would educate nurses to be managers as opposed to 'hands-on' carers, effectively grooming them to be leaders who direct a team of health care assistants (Naish, 1993).

The RCN, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), and the Board undertook the reviews. The recommendations accepted were those of the UKCC who proposed a new three-year programme of education and training called Project 2000.

The principal objectives of Project 2000 were a curriculum based on health rather than disease, the preparation of nurses who could function equally effectively in hospital and community settings and student status for trainees. The first 18 months of the programme provided a common foundation for the subsequent 18 months when students follow their chosen specialty in an elective branch programme. Nursing concepts, particularly the notion of holistic, individualised patient care, formed a core element of the framework. At last, after nearly 100 years of argument and dissension, a radical approach to nurse education that removed the last vestiges of the medical model was accepted. The introduction of Project 2000 began in 1986, alongside the gradual cessation of second-level nurse training.

2.3 Significant factors in the development of pre-registration nurse education

Issues that fuelled the conflicts and so hampered the development of nursing range from political naiveté to a limited conception of nursing and its contribution to health care. The factors that had a specific influence on nurse education can be located in the struggle and ensuing conflicts surrounding debate about who controlled regulation and standards of practice and whether to relinquish the apprenticeship system in favour of a more educational approach. Some problems stemmed from an inability to articulate the nature of nursing and from support for separate entry gates that led to a distinction between registered and enrolled nurses. There

were also dominant sections of the profession whose vision was obscured by vested interests, who obstructed repeated attempts at reform. Perhaps the most significant factors which held back the nursing profession are the following:

- the failure of nurse education to recognise the need to focus on nursing issues
- the failure to recognise the need to educate as well as train for practice
- the failure to provide knowledge which provides a common understanding for the basis of practice.

An important message coming out of the historical analysis is the need to develop nurses who are capable of recognising the wide range of issues that impinge on their practice. It requires skill in critical appraisal, which will better equip the profession, as a whole, to take a considered view of any recommendations put to it. This would enable nurses to respond to change with vision and critical understanding.

2.4 Matters of concern for pre-registration education in the 21st century

To generate an ideal approach to nurse education significant issues in today's health service must be addressed. Lessons from the past were therefore used to seek out factors in pertinent reports that have an important bearing on nurse education in the 21st century. The context within which education functions, the process of education itself and the desired outcomes was the framework used to give a structure to the search.

2.4.1 Context

The context within which nurse education functions comprises the National Health Service (NHS) for whom students are prepared and the universities which are now responsible for programmes of education. Two messages from the past apply to issues appertaining to the context:

- the necessity for education to focus on issues that are relevant to practice
- the need for an environment in which students are encouraged to think for themselves.

Using these two issues to seek out information from relevant NHS reports, issues relevant to practice were located in the Department of Health's strategy for nursing, midwifery and health visiting (DoH, 1999). In this strategy the changing context of care in the new NHS is described, together with specific targets for nurse education. In the section on the changing context of care, the document outlines the need for *'an increasing emphasis on integrated care, chronic disease management, disease prevention and the encouragement of healthy lifestyle choices and self-care'* (DoH, 1999: 8).

The educational targets require nurse education to consider more flexible pathways into and within nursing education, the inclusion of more practical experience to improve students' practical skills and training that is more responsive to NHS needs.

The issues relating to context that come out of the strategy document pertinent for pre-registration nurse education are twofold:

- programmes of education must include content concerned with both chronic and acute illness, and address the promotion of health as well as the management of disease
- universities, in which all nurse education is now delivered, must work closely with the NHS to ensure that programmes are designed to meet the needs of patients and to support the career pathways of students.

The current situation in the university sector, and the specific evidence from the case study data, both discussed in Chapter 6, reveal that there is much in the context of current nurse education that is not optimally suited to guaranteeing that these targets can be met.

2.4.2 Process

The process of pre-registration education includes curriculum design, management of clinical placements and the expertise of those responsible for delivering the programmes. Particularly relevant lessons from the past are the need for a common understanding of practice and a preparation that educates as well as trains nurses for practice. The current report that addresses the process of education is the UKCC report on pre-registration nursing (and midwifery) education chaired by Sir Leonard Peach (UKCC, 1999). Its recommendations are comprehensive, covering a wide range of issues. An important observation concerned the need to ensure that pre-registration students are capable of adapting to changes in health care needs within the population. The report also recommended that the critical shortage of nurses currently experienced by the NHS be addressed through a more flexible entry into pre-registration programmes using accreditation of prior experiential learning (AP(E)L).

In relation to curriculum design, the report has a number of recommendations. It addresses the thorny question of theory and practice by recommending that there should be a sequencing and balance between the two, favouring an approach whereby knowledge is integrated with both attitudes and skills. Considerable attention is given to the matter of clinical practice. Recommendations include its timing, the formalisation of arrangements for access to the practice areas and the provision of adequate preparation, support, and feedback to the mentors who assist students. As part of the committee's concern was to strengthen teaching, the report recommends that a number of methods be used such as experiential and problem-based learning, simulation in dedicated laboratories and information technology. Chapter 3 addresses the foundational question of how the relation of theory and practice should be conceptualised, and how this then relates to our understanding of the processes of learning in nurse education.

In relation to the expertise of those responsible for delivering programmes of education, two issues are raised. One concerns the breadth of expertise now required of nurse lecturers in order to provide teaching in clinical practice, management, assessment, mentoring and research. The report recommends that this be addressed through a team approach involving groups of staff, who between them, can provide the full range of expertise needed. The second covers the learning and clinical practice needs of academic staff, particularly the requirement that they keep up their clinical expertise. The report recommends that this be addressed through staff development. However, fragmentation of the educational environment revealed in Chapter 6 underlines the challenge faced by universities in guaranteeing the continuing clinical experience of their staff.

Key issues pertinent to the generation of the ideal approach thus concern all aspects of the process. In relation to curriculum design, special attention needs to be paid to academic content to ensure it reflects current priorities in health care. Clinical practice must be a prominent feature of students' learning experiences, driving both their knowledge and skill acquisition. Finally, the needs of teachers, so central to the success of education, must be considered. There is a clear message for the universities; they must recognise and address through their recruitment policy the overwhelming demands pre-registration education makes on nurse lecturers.

2.4.3 Outcomes

The outcomes of pre-registration nurse education measure the competencies students acquire and judges them according to their fitness for practice. The current document addressing issues to do with the outcomes of pre-registration nurse education is again that of the commission chaired by Sir Leonard Peach (UKCC, 1999). The significant lesson from the past is the need to ensure that students are educated as well as trained for practice. The report addresses this issue in considerable depth. First it recommends that competencies cover both theory and practice, are core and specific to nursing, are transferable and at a level consistent with the threshold set for degrees and diplomas by the Quality Assurance Agency for Higher Education (QAA). The outcomes and competencies for the formal learning component should give direction

to the clinical placements and practice outcomes should be judged according to fitness for purpose, evidence of rational decision-making and clinical judgement based on a portfolio of practice experience.

The key issue of outcome raised by the report concerns the content and structure of competencies. The discussion stresses the need to use well constructed, measurable competencies that cover both cognitive (i.e. judgement and decision-making) and practice skills. Every effort should be put into ensuring that these are transparent to everyone involved – students, assessors and mentors. However, the argument developed in Chapter 4 and the nature of clinical judgement discussed in Chapter 8 provides a clear warning against employing overly reductionist definitions of competencies.

2.5 Key pointers for future pre-registration nursing education

The ideal approach to pre-registration nurse education generated for the purposes of the research project is based on the major implications drawn from the historical review and the pertinent references made to education in recent Government and UKCC reports. It is presented as a list of issues that should be evident in any educational system involved in the preparation of student nurses for registration. There are eight key points:

- The university must have good, well-established working relationships with the NHS trusts with which they collaborate. The relationship needs to be based on trust and mutual respect.
- The formal component of pre-registration education programmes should cover issues relevant to the current needs of the NHS. This should include chronic and acute illness, the promotion of health and the management of disease.
- Both the formal and practically-orientated parts of the programme should challenge students to integrate theoretical knowledge with attitudes and practice; and promote a capacity for critical reflection.
- Clinical experience should be a prominent feature of students' learning experience, driving both their knowledge and skill acquisition. It should be designed so that it facilitates development of both their cognitive and practical skills so fitting them for practice (fitness for purpose).
- Programme outcomes should be measurable using well constructed competencies and transparent modes of assessment.
- All nurse educators should have first-hand clinical experience and work in teams that encompasses a range of expertise.
- There should be active, co-operative working links between the university and all practice areas in which students are placed for clinical experience.
- Educational management practices should foster staff ownership of all aspects of the programme.

This review and these assertions relating to education and practice provide a framework within which the research data were analysed, and the implications of the findings developed in Chapter 9.

3.1 Selection of methodological approach

This project has attempted to study the construction of the identity of the nurse and account for the acquisition of key skills and competencies in nursing. The aim was to suggest ways in which the education process can be better geared to preparing nurses for practice. Originally, the aim was to look for the relevant cognitive and affective processes that nurses use in the delivery of holistic and individualised care, but from the outset it was clear that this terminology was outmoded. Much of the current literature stresses the embodied nature of providing nursing care and this approach is argued for in Chapter 4. The research methodology therefore needed to be in harmony with the researchers' general view of what it is that nurses do. Because it is argued that skills and competencies must be understood in the light of the construction of an identity – that of the professional nurse – and that this takes place within given contexts located in time and space, it followed that data gathering should occupy those same times and spaces.

Because of this need for ecological validity the methods of study selected were ethnographic and interpretative. Ethnography has been defined as *'the direct observation of the activity of members of a particular social group, and the description and evaluation of such activity'* (Abercrombie et al., 1984). Given the emerging importance of the concept of 'communities of practice', the use of the ethnographic method was especially important. If ethnography involves the observation, description and evaluation of the activities of a social group, such a method is entirely appropriate for the study of communities of practice. The word 'ethnographic' means 'portrait of a people' (Burns and Grove, 1993) and this is exactly what it was hoped to provide through this study: not only a portrait but also an analytical understanding of nursing practice within its everyday context. It is argued that only in this naturalistic setting can the skills and knowledge nurses use every day, in hospitals and the community, be properly identified. Furthermore, these competencies can only be identified in the terms that nurses themselves use to identify them, rather than imposing an academic language that may be unfamiliar to practising nurses. This is why the emphasis on the terms cognitive and affective was abandoned: nurses themselves did not recognise such terms. Nurses in various practice settings and those working in nurse education said time and again that they did not use these terms. Staying true to the ethnographic spirit, the researchers decided not to use them either.

Ethnography, therefore, is a style of methodological enquiry that enables the researcher to gain access to the meanings contained in a culture, which guide its members' behaviour (Hammersley and Atkinson, 1983; 1995). Ethnographic approaches gave the researchers the means to access the beliefs and practices within nursing by immersing themselves into the culture of the nursing communities studied, examining that culture from the subjects' perspective. Participant observation was the main tool chosen for studying nurses' practice in clinical settings, backed up by critical incident interviews. It was felt that this would allow entry into various communities of practice in order to study nursing in its everyday setting. Critical incident interviews allowed access to nurses' views about their own practice when reflecting on incidents that had occurred on the ward. In such interviews nurses were recorded talking about what they saw as their key skills and competencies; extracts from these interviews form the main bulk of quotations from qualified nurses and student practitioners throughout this text.

3.2 The relationship between theory and practice

The researchers have not approached this project believing they can achieve some neutral representation of 'the facts' free of their own interpretation. Empirical research is shaped by the paradigm commitments of the researchers (Denzin and Lincoln, 1998), as well as their

theoretical orientations. Such predispositions and orientations must be honestly acknowledged and thoroughly tested in the research process. Where a theory or concept does not fit with the emerging data it should be either discarded or reworked. At the beginning of this project the researchers wrote a position paper, setting out their theoretical orientation to the subject and methods of research. It was felt that the notion of 'communities of practice' (Lave and Wenger, 1991) would be highly appropriate to the research, and so it proved to be. However, the researchers also intended to apply Bourdieu's concept of the 'habitus' to nursing practice, suggesting a structured set of acquired practices which are spontaneously, almost unconsciously, produced in the appropriate contexts or 'fields' (Bourdieu, 1977; 1990). However, this concept did not fit with what was seen, heard and recorded in the various communities. This is not to say that the concept of the habitus has no value in its practical application; it simply did not seem to apply to, or add any value to, this research, and the term was not used. From this experience, the empirical research can be seen as a dialectical process: a subtle interplay of theoretical reflection and practical observation and conversation, from which emerges new insight. In this way, the study was always developing and open to reinterpretation.

This dialectical interplay between theory and ethnographic research was forged at the beginning of the project. Whilst writing an initial position paper and discussing various theoretical approaches, the researchers were also conducting focus groups with nurses, student nurses and their mentors. Here they began to test the language and ideas by which the study had been framed and to listen to the ways in which nurses described and explained their practices and skills. So the study began with focus groups and extended into participant observation and critical incident interviews, alongside interviews with staff in a university school of nursing. It was hoped this would facilitate the development of an understanding of the everyday communities of nursing practice in various contexts, including the way student nurses become members of these communities, and the way in which educators prepare students for practice. Focus groups were used to give the researchers conceptual bearings within the world of nursing practice and education.

3.3 Pilot study methodology: focus groups

The use of focus groups for collecting qualitative data has recently received a high public profile. Their use for gauging public opinion is an example of how the they have entered into mainstream culture. The popularity of the method is also evident in the exploration of nursing practice (Kingry et al., 1990; Mackintosh, 1993; Torn and McNichol, 1998).

During the pilot stage the researchers conducted focus group interviews with student nurses and their mentors. The focus group has traditionally been used as a way of generating hypotheses and informing research development, but also *'the synergy of the group has the potential to uncover important constructs which may be lost with individually generated data'* (Kingry et al., 1990: 125).

Certainly, the researchers were able to draw out the perceptions of those who participated in a way that illuminated their approach.

The interviews were based on a semi-structured framework focusing on topics the researchers wished to discuss. The questions aimed to establish interviewees' perceptions and understandings of the terms cognition and affect, whether they had heard these terms used in practice or used the concepts themselves. The researchers also wanted to know about their understandings of holistic and individualised care, how they made assessments through this framework, and their views of nursing as a profession. Four groups were convened representing:

- adult branch students
- mental health branch students
- adult nurse mentors
- mental health nurse mentors.

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In addition a symposium of practitioners and educators was convened for a one-day seminar, for further conceptual clarification. These discussions were audio taped, transcribed and turned into synoptic accounts, then the verbatim transcripts were thematically analysed.

3.4 Main study methodology: participant observation and critical incident interviews in clinical and community settings

Participant observation is one of the main methods used in ethnographic research and seemed highly appropriate to the study. As two of the research team were qualified nurses – one in adult nursing, the other in mental health – it was possible for them to join various communities of nursing practice. Field and Morse (1985) identified four types of participant observation, which vary according to the degree of participation of the researcher, ranging from complete participation where the true role of the researcher is concealed, to complete observation where the researcher observes from the periphery with no participation or interaction. In this study the 'participant as observer' method was used, in which the researcher plays a full role in the activities of the group, yet subjects are aware of the dual role of the researcher and the purpose of the study. This method was felt to have several advantages:

- deception of subjects is avoided, thereby clearing one of the main ethical dilemmas of participant observation – that those being studied are not aware of their participation
- the roles and responsibilities of the researcher can be openly negotiated
- the researcher has the opportunity to gain credibility and acceptance within the community of practice by working as a nurse
- data may become available to a participant that would not be accessible to a researcher in the role of an observer standing outside the practice
- the processes by which individuals become members of a community are also opened up for study.

However, the participant as observer method also has a number of disadvantages. There can be a conflict of roles for the participant observer who could be caught between being a researcher, on the one hand, and a qualified nurse on the other; for example, if the researcher observes bad practice that may put the patient in danger or their successful treatment in jeopardy, do they intervene? It was agreed that if such extreme circumstances did arise, the role of nurse would take precedence. However, in more 'routine' forms of bad practice that did not endanger patients or put them in unacceptable discomfort, the researchers did not intervene.

There is a risk of decreased objectivity as a consequence of occupying the two roles of nurse and researcher for, as a qualified nurse, the researcher may make judgements about the clinical practice being observed. Alternatively, the researcher could become attached to the nursing team and collude with them in a way that might influence the study.

Finally, the fact that the participant observer is identified as a researcher may bring about a change in behaviour. The researchers believe that this was offset by the participant observer working in the community of practice over a period of time, thereby exchanging their work for a degree of acceptance and trust, reducing any perceived threat to staff being observed.

The disadvantages in the method of participant observation were openly acknowledged so that all the research team were conscious of them. The length of time spent in the field was also important: participant observers stayed in a placement for 4–6 six days. This was felt to be enough time for them to become part of a team and to observe practice, without becoming too drawn into it. As a new but useful member of the community, the participant observer was accepted as a co-worker without entirely becoming 'one of us'.

However, there is a further issue to be dealt with when considering validity in participant observation: the question of whether or not researchers can claim a valid representation of a world 'out there' that exists independently of their study and its theoretical framework. With the turn to post-modernism in the social sciences, texts produced by ethnographers to describe their field of research have increasingly come to be regarded as 'fictions' rather than scientific, therefore 'factual', representations (Geertz, 1973). That is, ethnographers use literary styles and competencies to reconstruct the social action witnessed or participated in, and to talk about social actors they have engaged with (Atkinson and Hammersley, 1998). The research field can never be objectively represented for it is written about in story form, using culturally accepted forms of narrative exposition. As in any story based in actual events, the storyteller's perspective is always from their personal point of view; and there is also the issue of what is not told.

While the researchers accept many of the points made by post-modernist researchers, they do not completely accept the view of the research text as fiction. Although the process of writing up field research is obviously subject to literary conventions, this does not make the world it describes a complete invention. Just as fiction can be evocative of a particular social world, so too can reports of participant observation evoke the world the researcher has been immersed in. Moreover, the writings of the participant observer are based in actual joint activities composed of more than one person and their imagination. Participant observation describes a world of reciprocity of perspectives composed in actual interactions. This report does not claim to describe a world observed in a neutral fashion, but tries to capture some of the flavour of interactions. In that sense, it describes a world that, as participant observers, the researchers partially helped to construct while in the field and while writing. At the same time, though, as *one* participant in a network of joint activities, the researcher did not wholly construct the community. While the researchers' voices are here in their interpretations and theories, these are not the only voices, for in the text nurses of various grades and statuses are speaking about their experiences and what is important to them. It has been the researchers' desire to have these voices heard and not to impose an academic language where this is not appropriate.

The university chosen as the research site gave access to the full range of clinical placements and offered a full compliment of pre- and post-registration programmes. It was also regarded as representative of good quality nurse education. Access for the participant observation in clinical settings was granted by the chief nurse of a university-affiliated trust, and honorary contracts were set in place for the adult nurse and the mental health researcher to engage in participant observation in eight settings:

- stroke rehabilitation ward
- surgical ward
- medical ward
- accident and emergency unit (A&E)
- psycho-geriatric ward
- acute psychiatric ward
- community mental health team (CMHT)
- hospice.

Access was negotiated with individual wards by contacting and meeting the senior nurse. At this meeting the project, the role of the researcher on the ward, work times and dress code were discussed. Nurses and students in each setting were then asked for permission to be shadowed. In each setting, where possible the following were shadowed and observed:

- one qualified nurse with recent (completed no more than six months ago) or current post-registration education (diploma level or ENB Higher Award)

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- one qualified nurse with no post-registration education in the past 12 months
- one Project 2000 student nurse.

Unfortunately, this was not always possible, as there were no Project 2000 students in the hospice, CMHT and A&E sites. The students on placement in the CMHT and A&E were on short observational placements only, so it seemed inappropriate to observe them. The acute psychiatric ward had no qualified nurses with recent accredited post-education experience, although many had completed more informal training. In all, 20 participants were observed and interviewed:

- qualified post-registration: 7
- qualified non post-registration: 8
- Project 2000: 5.

Whenever possible, the researchers met the individuals being shadowed prior to the observation to discuss the project. The point of shadowing particular nurses was to get a more in-depth understanding of their daily practice. However, there was constant interaction with other nurses, along with encounters with doctors and other staff. Everyone was aware of the researcher's role and of the study.

The participant observers spent 4–6 days each in of the settings, working with and observing the nurse they were shadowing and noting interactions they were involved in. Observations of the interactions and settings were recorded by extensive note taking done away from the research setting so that it did not interrupt the flow of joint activity. It also helped the nurses to relax and forget that they were being observed, acting as naturally as possible.

For each nurse shadowed, a semi-structured critical incident interview was audio taped, focusing on an agreed incident that had taken place during the time in which the nurse and the researcher had been working together. This incident was used as a springboard to widen the discussion around themes relevant to the project, especially the skills that nurses felt were central to their practice and the influence of any programmes of education they had taken. Twenty interviews were transcribed, sections of which are used throughout this report to illustrate key points.

3.5 Main study methodology: educational interviews and focus groups

3.5.1 Semi-structured interviews in the school of nursing

This stage of the research started with a clarification of agreed access with the personnel who would become immediately involved in the research. After an initial meeting with senior programme managers to inform them of the project and proposed methodology, a further meeting was arranged with a broad range of teaching staff. These meetings proved invaluable since amongst other things they revealed a high degree of anxiety about a formal programme review, within the framework of a teaching quality assessment, which was anticipated in the foreseeable future. There was concern that the research might add to this anxiety and/or generate uncomfortable information that might in some unanticipated way contaminate their review.

Resolving this concern did much to clarify the parameters of the research and its mechanisms of confidentiality. In the analysis every attempt has been made to exclude information that might reveal the institutional identity. Through this process the research was perceived as a useful contribution to preparing for the review by aiding staff reflection on their current policy and practice. Interviews with staff and focus groups with students were marked by a degree of openness and genuine interest in the research that belied the anxieties initially exposed.

In a large multi-site school of nursing the potential population of staff to be interviewed far outstripped the resources of the research. Individuals were selected through an iterative process that started with examination of the curriculum documents. This generated a view of pre- and post-registration provision within the school that allowed for an initial selection of areas of the curriculum that would be tapped. Discussion with programme leaders advanced the process of identifying individual members of staff. Ultimately individuals were selected in order to generate a broad range of expertise, and to reflect the administrative structuring of staff over the curriculum. Interviews were carried out with 18 academic staff and separate focus group discussions were held with participants in seven post-registration programmes.

All interviews and focus group discussions were tape recorded and subsequently transcribed. The framework method of analysis was echoed in the analysis of these data, which was initially carried out by two colleagues who had not been involved in the data collection. At the point of mapping and interpretation one of the team who had been involved in the data collection revisited *all* transcripts in the light of the analysis to date and produced the final interpretation. This process allowed the existential component of the data collection to inform the final analysis. Amongst other things it brought the 'voice' of the interviewees back into the account of their community of practice. The relatively small number of interviews carried out in the examination of post-registration education underlined the appropriateness of the qualitative analysis employed in Chapter 6.

3.5.2 Focus groups

The focus group method was also used in the collation of educational data in the main study from post-registration students on seven programmes:

- Teaching and Assessing
- Diploma in Professional Studies (Elderly Care)
- Counselling
- A&E
- Palliative Care
- Orthopaedics
- Burns
- Clinical Supervision.

Students were accessed by lecturers, who first gained their permission to conduct the group discussion. A researcher then conducted a one-hour focus group with students who agreed to participate. A brief outline of the study was given to the students, together with assurances of anonymity and their right to withdraw at any point. Data arising from these focus group discussions were subjected to an inductive process of analysis, where themes and categories identified from the data guided the emerging theory.

3.5.3 Analysis of data

The study yielded data covering a variety of themes. It is the analysis of the data that lends the qualitative method of research coherence, by identifying and defining key concepts and by mapping and categorising the emergent behaviours and themes (Ritchie and Spencer, 1994). This study adopted the 'framework' method of qualitative analysis, defined as: *'an analytical process which involves a number of distinct though highly interconnected stages ... it relies on the creative and conceptual ability of the analyst to determine meaning, salience and connections'* (Ritchie and Spencer, 1994: 177).

There are five stages involved in the framework method of qualitative data analysis.

The first stage was 'familiarisation', where researchers became acquainted with the data by reading and re-reading field notes and transcripts, and by listening to taped interviews. Through familiarisation, the analyst can get a 'feel' for the data and begin to note any ideas or recurring themes.

In the second stage, identifying a thematic framework, these themes provided a basic framework from which more detailed analysis could be undertaken, to reflect the richness and diversity of the data. The data were then reanalysed, and the emergent themes were collapsed into broader categories by making judgements about the meaning of a theme and its connection to others.

In the indexing process, the third phase, all textual data were subjected to the thematic framework using a system of numerical coding. This enabled all members of the team to refer between the index and the text in order to locate instances of particular themes or concepts, and helped to clarify and verify the analysis, which was visible and open to critique and reformulation. During the indexing process sub-themes emerged and multiplied as the analysis became more refined, reflecting the richness of the data.

Once the thematic framework had been applied to the clinical data and the indexing completed, the occurrence and juxtaposition of themes and categories needed to be reviewed by looking at the data set as a whole. In this phase, charts were drawn up for each category, mapping the presence or absence of themes in the field notes and transcripts. By this time, the research team was sufficiently acquainted with the data to immediately locate individual themes within the texts.

In the final phase, once all the data were categorised and charted, the whole data set was interpreted in order to complete the analysis. The mapping and interpretation stage of this study forms the basis for the following chapters.

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4.1 Introduction

It has been said by Davies (1995), among others, that nursing is an activity that resists clear definition, as it is made up of many disparate and seemingly contradictory elements. There are aspects of domestic work that is often associated with 'women's work', such as caring for members of the family; however, there is also a high level of technical skill and know-how, including knowledge about the body and its functions and malfunctions, and about medicines and other treatments. In between these two forms of activity and knowledge there is also knowledge about the business of caring itself, about the emotion work that goes into building a caring relationship and the use of self within that relationship. In other words, the act of caring itself is opened up to scrutiny and the whole issue of emotional labour is raised.

Initially, this research was an exploration of the cognitive and affective processes involved in making individualised care plans and delivering holistic care. However, it soon became clear that the categories of cognition and affect would not help much in understanding how nursing activities are carried out and care plans are developed, because nursing is such a complex activity. Nursing involves the building of caring relationships and the emotional attunement needed for this, as well as the employment of technical and rational knowledge, and it became impossible to say which activities were based in the rational, mental aspects of thought and knowledge, and which were oriented more by the feeling or emotional aspects. Furthermore, in the social sciences, this separation between thought and emotion has been criticised. The idea that humans can be divided between a rational, cognitive aspect of being and one that is emotional or bodily, can be traced back to the 17th century philosopher Rene Descartes. 'Cartesian dualism' states that humans can be divided between mental and bodily substances or essences, with the mental representing the human level of functioning. Descartes reasoned this was so because he thought that the mental process of rational decision-making allowed humans a level of freedom in thought and action not available to other animals. The bodies of all animals, including humans, are automata which operate and respond in a mechanical fashion, without conscious reflection. It is the developed human mind that allows the possibility of conscious knowledge, rational thinking and freely-chosen actions. While Descartes thought the body and the mind interacted, he believed they did so as different or discrete entities. However, social scientists have argued that the Cartesian dualism is a historical construct rather than a natural division between body and mind, a construct that emerged at a time when Western philosophers were attempting to establish the superiority of scientific reasoning above other styles of thought. The separation of reason from the body and the emotions is therefore bound up in the power relations of the 17th century, in which scientific rationality was struggling against religious knowledge, folklore and tradition. While this struggle for 'enlightenment' liberated many people from the older power structures of the church and aristocratic state, it established new forms of power relations where those who possessed rational knowledge were seen to be superior. This tended to be the educated male elite of the Western world. Other forms of knowledge such as emotional sense and intuition became subjugated and labelled as 'irrational'.

Alongside this academic and political opposition to the division between the rational mind and embodied emotion the researchers also found that this dualism did not fit with the data generated. In the participant observation, critical incident interviews and focus group interviews, nurses were found to use a range of styles of knowledge to assess patient need, devise care plans and nurse the patient. Nurses not only draw upon their scientific knowledge, they also use social skills in order to relate to and communicate with their patients, and such relational skills are inseparable from the quality of information a nurse gets about a patient. Equally, an emotional sense or intuition is often a key element in making assessments: knowing something

about the patient or their condition without the scientific or reasoned evidence to back this up. In fact, in highly pressured situations nurses often do not have the time to gain such forms of knowledge before they act in order to provide necessary treatments. Instead, clinical decisions are often based on observation of the situation or communication with the patient. The information gleaned from this is made sense of as much through emotional knowing and past experience, as through rational assessment. This is not to say that rationality plays no part in nursing, for evidence-based practice is an important part of delivering nursing care. It is simply to say that scientific knowledge or reason is only one means of making assessments and delivering care. Other forms of knowledge and action are just as important as scientific rationality, and coexist and work alongside it. It is therefore one of the tasks of this research to try to understand how rational and emotional forms of knowing are complementary and interact with one another in the delivery of nursing care.

The other important factor in the rejection of the cognitive and affective model is not just that it is impossible to say when a nurse is operating with one or the other capacity: the main reason for rejecting dualism is that it does not figure in the everyday language of nursing practice. When nurses were asked to talk about their activities they did not do so in terms of cognition and affect: indeed, there was uncertainty as to what these terms actually meant. While nurses often knew that cognition referred to thought processes, there was much confusion over the notion of affect. The word 'affect' was associated as much with the effect of an action as with emotion or feeling. Both terms were regarded as part of an 'academic language' that had little to do with daily nursing practice, or with nurse education. Indeed, the terms were also unfamiliar in the educational setting researched and were not generally used in the planning or delivery of programmes of education. It was decided instead to focus on nurses' accounts of their activities.

However, other social scientific concepts were useful to the researchers. All ethnographic research is framed by or interpreted in accordance with the theoretical or methodological approach of the researchers, and this research is no exception. The concepts the researchers have found useful are communities of practice (Lave and Wenger, 1991), power relations, the embodied practitioner, and time/space. These themes weave in and out of the ethnographic data, so it is useful to clarify them and say why they are so important to the understanding of nursing practice.

4.2 Communities of practice

Lave and Wenger's (1991) concept of communities of practice refers to any group involved in joint activities, who also reproduce the community over time by the gradual induction of new participants, or learners. Becoming a member involves learning the skills, knowledge and values of the community. However, Lave and Wenger reject the 'cognitive' model of learning, in which a novice is seen to gain expert knowledge through the learning of structures of thought, or schemata, which are then applied to practice. Instead, the novice is seen as a co-participant in the community of practice from the very beginning, albeit one who initially functions on the periphery of practice. The novice is not immediately allowed to be a fully participating member of the community, but has limited responsibility for a clearly defined and designated set of activities which are performed in close conjunction with an expert in the practices of the community, so that the novice is constantly mastering the practices they will one day perform independently as a fully fledged member, or master.

In this model learning is always situated, taking place within a specific community of practice with its own location and forms of practice, knowledge and values. To learn in such a context is not simply to master a range of concepts, to take into the mind a structure of thought through which the world is viewed; learning is embodied performance that involves engagement with the world and interaction with co-participants in joint practices. It involves the construction of an identity through participation in the community where one becomes 'a member such as

those', an expert in the field. In the process, new skills and knowledge are learned, but not in any disembodied or disengaged way: they are learned and mastered in co-participation with others and through the reformulation of a person's identity.

Becoming a nurse involves so much more than learning a body of knowledge about how to nurse a patient. It involves becoming a *nurse*, a certain type of person whose very identity is constructed and maintained through nursing practice. To become such a person, a nurse, one has also to start on the periphery of practice as a student nurse: one who co-participates, but to a limited degree. As the identity of the nurse is consolidated through this situated learning, she or he takes a greater role in the community and gains greater mastery over the required practices. The community is never at any point in time exactly reproduced because new and old members alike will constantly be bringing in novel ideas and experiences. Also, because a cognitive model of learning is not implied here, a given structure of knowledge will not endure through constant re-application: because the model of learning and practice is highly dependent on the context of the performance, there is always room for improvisation and change. Indeed, the situated and context-driven nature of performance *demands* practical innovation and improvisation, rather than mechanical reproduction of past actions or the framing of each situation in terms of a given mental schema.

This also means that the identities of the nurse and the community of practice are unstable and must be constantly reproduced in everyday practice. Similarly, the identity of the professional nurse is not secured upon qualification, never again to be questioned or challenged. A newly-qualified nurse is still a novice in many respects and will no doubt have fears and anxieties over their abilities to function as a full participant in the community. However, nurses who have years of practice experience still express the fragility of their identity. The data are peppered with examples of nurses feeling they continually need to learn new knowledge and practical skills in order to fulfil their role in the ever-changing landscape of nursing practice. While the identity of nurse becomes more secure as the individual gains more experience and expertise, the process of becoming a nurse is never finished: it is an ongoing process which opens the community to further change and continual reconstruction.

However, while the concept of community of practice was useful in these ways, there were also problems that led the researchers to innovate around it. First, in what sense can we talk about a community of practice in nursing as a whole? Is there any aspect of the profession that unites it and makes sense of the claim that 'I am a nurse'? The data clearly show great variation from context to context in the practices, skills, beliefs and identities of nurses. From nurses on post-registration programmes there was a clear sense of identity as a *particular kind of nurse:* 'I am a burns nurse', 'I am involved in palliative care', or 'I work in A&E'. Yet at the same time the generic sense of identity as a nurse, who shares a common core of skills or values, also comes through. It seems that nurses construct their identity in relation to *both an imagined community and an actual community of practice.* That is, the identity of nurse is formed in relation to an 'imagined community' (Anderson, 1981) united by core values, such as caring and nursing, but which remains imagined in that it is never actually constituted in space and time. This is unlike the community of practice itself, which is constituted on an everyday basis in face-to-face interaction and co-participation in nursing practice. What unites the community of practice is joint activity, performance, communication, learning 'on the job' and humour. However, the imagined community and the community of practice, though they can be made analytically distinct, are inextricably interrelated: the imagined community could not exist without actual communities of practising nurses, while communities of practice are informed and partly unified by the knowledge and values that constitute the imagined community.

The second problem encountered with the notion of community of practice and the idea of situated learning was that it is very much based in an apprenticeship model of learning. Learning is situated in a specific community where novices co-participate with old hands, a process through which the learner becomes a full participator. However, as shown in

Chapter 2, the nursing profession has in recent years moved away from a mainly apprentice-based form of learning and professional socialisation towards education based in universities. Student nurses, though, must still do practice placements and prove themselves safe to practice before they can qualify, at the same time proving themselves academically able through book learning, examinations and essay writing. In other words, they are now faced with two models of learning and two identities that need to be balanced: they are university students who are seen as rational, cognitive beings whose academic performance is mainly assessed through written exercises. When on placements, however, they are student nurses who must learn to co-participate in a community of nursing practice where their involvement and their performance will be assessed according to the practical criteria of how well they do the job, albeit initially in a limited fashion.

The competing demands facing students can be thought of as an example of the theory/practice gap (Cooke, 1991; McCaugherty, 1991), in which theory is seen as something abstract and divorced from practice, while the real business of nursing goes on in practice settings, wherever nurses nurse their patients. This was expressed throughout the research, especially by practitioners who feel divorced from the process of education in universities and who also feel that the students they get on placement are 'all theory and no practical ability'. In the first focus group at the beginning of this project a student mentor claimed she had encountered a third-year student who 'knew all the theories but couldn't even give an injection'. Thus it is claimed that Project 2000 is wanting because it concentrates on academic rather than practical expertise.

However, the researchers do not feel that this problem is an example of the theory/practice gap or that current student nurses are too theoretical. (Indeed, in other seemingly contradictory statements the same practitioners often praised Project 2000 students for their ability to challenge accepted practices and bring new ideas into practice). Rather, the problem stems from the different locations for two types of community of practice, each with distinct roles: one is located in the schools of nursing and the other in the various contexts in which nursing care is delivered. In the school of nursing the aim of joint practices is to educate students in the different kinds of knowledge they will need in practice and, for academics, to generate research and knowledge in order to advance nursing practice. One could say, then, that the main practice is to generate discourse *about* nursing practice: to teach students the theories of nursing and the basics of physiology and psychology and any other knowledge it is felt will benefit them. In contrast, on hospital wards and in community settings the aim of nurse practitioners is to jointly *practise* nursing care, and any discourse about nursing is mainly used in the course of practice or, in reflecting on it, to improve the specific nursing team's performance.

This means students are caught between these two communities. Because of the history of nurse education prior to integration with universities, and because of staff shortages and resource problems, on placements they are expected to be another pair of hands who can perform basic tasks without too much supervision. Students also need to fit into the practice setting by forming good relationships with nurses and mentors, becoming part of the community of practice and learning within it. This means that they must have some practical skills to trade for becoming a peripheral member of the community. Students may be working alongside nurses who have little time (literally and metaphorically) for their theoretical knowledge, in which case the main thing they have to contribute is not highly valued. In short, students must survive both in the university, where they are assessed by the demonstration of academic skill, and on placements where learning is based in practice and they will be assessed on performance. This is discussed further in Chapter 6, which considers how education attempts to meet student needs.

4.3 Power relations

Communities of practice, however, are not hermetically-sealed units closed off from outside influence, nor are the relations within them necessarily equal and harmonious. A

community of practice is related to other communities of practice and there may be power struggles both between and within them. Indeed, the very idea of novices entering the community on the periphery of practice suggests an unequal power relation between learner and established members. How communities of practice overlap and compete can be illustrated by the relationship between the nursing and medical professions – two communities of practice whose functions often overlap, especially in terms of the medical care of patients. Increasingly, in some settings, nurses are taking over what once was the exclusive domain of doctors, such as performing minor operations. Yet within nursing there is still the range of knowledges and caring duties discussed earlier – such as bathing patients and dressing their wounds – that is the exclusive province of the nursing community. Moreover, many argue that these are still necessary elements of nursing practice, for it is during encounters with their patients that the nurse may glean bits of vital information about the patient's condition, both physical and emotional; as is illustrated in Chapter 7, nurses are mainly responsible for the emotion work done with patients in these contexts.

It is this range of knowledge, skill and practice that often puts nursing low down in the power hierarchy of the health care system. As Davies (1995) pointed out, much of nursing practice has traditionally been regarded as 'women's work', especially caring duties in which nurses attend to patients' basic physical needs. Looking after the young, the sick, the elderly and the infirm has traditionally been part of the unpaid domestic duties of women, and so it has ranked low in terms of occupational status and pay. That nurses claim that such caring duties are an essential part of nursing practice has often disadvantaged the profession in the gendered power structures in which it must compete. Hopefully, if this research has achieved anything it is to show how essential the whole range of practices, skills and knowledges are in nursing. However, that will not make the occupational power structures of the health care system go away: instead, these should be honestly acknowledged as one of the aspects that determine the context in which nursing practice takes place.

A good example of how this power structure works on an everyday level was seen during a participant observation of a registrar's ward round on a surgical ward. On the morning of the observations, the consultants had rotated their teams so that none of them knew anything about the patients they had to treat, and the staff nurse had to inform the doctors of each patient's history. In doing this she attempted to communicate in medical discourse – presumably because this is what she felt the doctors expected – referring to symptoms, signs, investigations, results, and previously discussed possible future options. In attempting to use medical discourse, the staff nurse stumbled over many words and generally looked uncomfortable, causing the doctors to flash impatient looks towards her and between themselves. In their willingness to display their feelings they were clearly communicating the view that the nurse was incapable of mastering their level of medical expertise. The effect of such behaviour, however, is even more dramatic for the patient, who becomes the only person not able to participate in the discussions on any level. The patient is excluded because of the indecipherable nature of the discourse, and is also not expected to speak because their symptoms are the only point of interest to the medical team. In this situation the patient is not seen as an embodied person with a voice and a right to speak and be heard, but only as the parts and symptoms of a depersonalised body. They have been fragmented into mechanical body parts and symptoms and, as such, have lost the rights of personhood.

The existence of power relations in the micro-fabric of everyday interactions is further illustrated by another encounter on the same ward round, this time with a patient admitted because he is losing blood from his rectum. As the doctors and nurses approached his bed the patient said good morning, but the participant observer was the only one who answered. The registrar used bodily and facial movements to show exasperation while the nurse told him about the medical details. Again, this made the nurse uncomfortable and she began to stumble over her words and to develop word blindness, particularly for medical terminology, at which the registrar displayed more non-verbal signs of impatience. The two senior house officers

stood silently, looking embarrassed. After X-rays were found that indicated the patient had at some time fractured his shoulder, the following conversation between the registrar and the patient ensued:

Registrar: *'When did you break your shoulder?'*

Patient: *'Last year: I fell in the house and landed flat on my back.'*

Registrar: *'And you broke your shoulder?'*

Patient: *'Yes.'*

Registrar: *'Do you often fall in the house?'*

Patient: *'No.'*

Registrar: *'Sure?'*

Registrar: *'What age are you?'*

Patient: *'Sixty eight next birthday.'*

Registrar: *'So in fact you're only 67!'*

Patient: *'No response.'*

In this interaction, the registrar emphasised his power and superior status by silently allowing the nurse to get flustered over the medical discourse. Then, in the only verbal interaction with the patient, he searched for information by posing a question to which the answer was obvious while using a style of questioning that implied knowledge of a superior nature. The patient's responses were questioned in a way which suggests doubt over their reliability, and the figure of speech the patient chose to report his age was used as an occasion for a put-down and a further emphasis on his lack of accuracy. During the latter interchange the doctors exchanged momentary eye contact, which affirmed a knowing bond between them and also signalled that the patient was a fool. This interaction shows how doctors may have felt they had ultimate control over knowledge of the situation and were the only ones with mastery of the medical discourse, with the nurse and the patient put in their places.

Power relations also exist within the community of nursing practice itself. Mackenzie (1997) has shown how enrolled nurses are generally given tasks that involve attending to patients' bodily needs and functions, while higher-grade nurses deal with the more 'hi-tech' aspects of care. However, some enrolled nurses turn this around and claim their work involves the 'real' nursing care, rejecting the more high status technical role and the education this involves. As already noted, there is a strong argument in debates about contemporary nursing care that nursing practice should involve the whole range of duties and skills. This debate, though, is both stimulated and circumvented by the power relations in which nurses are enmeshed, both within their own community and between the nursing community and other professions.

Nursing practice is increasingly influenced by a range of power relations embedded in wider society, involving economic, political and managerial forces. It is argued that the economy is becoming ever more determined by processes of 'flexible accumulation' (Harvey, 1990), and this has had a massive impact on the welfare state in Britain. Flexible accumulation describes the economic conditions that have prevailed from the mid-1970s onwards, characterised by the break up of labour control practices, consumption habits, and the style of Keynesian economic planning practised by post-war governments. Attempts by governments to carefully plan and control political and economic systems were abandoned, and instead markets have been given free reign. This led to a social and economic system where there is rapid change, flux and uncertainty (Harvey, 1990). Flexible labour markets and labour processes have also meant that workers must be more adaptable in their working practices, ready to face constant change and accept multiple roles.

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For nurses working in the British welfare state, this has meant they have faced tighter control and management of resources, including their own labour. Greater demands are placed upon them to be more 'efficient' in the delivery of care, which generally means fulfilling a multiple range of tasks and having less time to spend with patients. Many nurses have found themselves increasingly preoccupied with managing the delivery of care, which is provided by other nurses or professionals, rather than getting involved in the day-to-day practice of caring (Davies, 1995). However, this research showed this picture to be somewhat overstated, and that the majority of nurses are still involved in actively providing nursing care. Yet there is no doubt that the context of nursing care has changed to one where fewer nurses are used more effectively, creating greater pressure on their time and stretching their skills. The role of management in this situation has also increased, meaning that nurses face an ideology of the efficient use of resources which may be at odds with their professional values of caring for the patient (Olesen and Bone, 1998).

Overall, what this means is that communities of nursing practice are not self-contained entities: they are located in the social, political and economic world. In having to work in these contexts, the communities of practice may find it difficult if not impossible to enact the core values of their imagined community: for example, caring for patients' needs as their primary goal. In actual communities of practice restrictions on time and other pressures may mean that core values become a distant ideal, so that everyday working practices are experienced as unsatisfactory. However, this is not always the case: the data are rich with examples of successful nursing outcomes and satisfactory, if not ideal, working environments.

While agreeing with a theorist like Foucault (1982), who believed that power is endemic to every human relation and is about the management or government of the field of action, the researchers feel the everyday strategies that people use to subvert the government of their actions and to practise an alternative set of values are missing from this viewpoint. Furthermore, while Foucault claims that the only route open to modern individuals in resisting the government of their actions is a refusal of the identities foisted on them, the researchers believe that in resistance people call on alternative sources of values and identity. In nursing, this is the imagined community where the core values of nursing remain uncontaminated by the daily compromises and political tensions of the workplace. While others have seen nursing values as an idealism that acts to smooth over the turbulence of practice and education in current organisations (Stark et al., in press), the tension between the imagined community and the actual communities of practice is a necessary, if uncomfortable, one. Without the imagined community and its ideals, nurses would have no reference point for a critique of the current health care system and the restraints it places upon the delivery of nursing care, nor would they have a vision of what nursing care should be like.

This vision can lead to the virtuoso performance of good quality nursing care in environments that are not always supportive of it. The term 'virtuosity' is used here in the way it has been employed by the anthropologist Richard Bauman (1986), for whom it is the expressive competence to evoke an imagined reality in the performance of various activities. This idea fits well with the researchers' observations, in which nurses have often put on virtuoso performances, enacting the values of their imagined community in workplaces where there is neither the time nor the resources to properly support such practices. One could see these performances as focal points of resistance through which nurses, in these small, everyday virtuoso acts, transcend the limits of management control and scarcity of resources. While it must be realised that such ideal performances and values may never be permanently secured in practice, nurses may become even more demoralised, disheartened and, more importantly, depoliticised if they were to let them go. Yet it does mean that nurses live in the tension between their ideals and the realities of practice, only occasionally achieving the kind of performance they would wish for their patients.

An aspect of the Cartesian dualism that resonates well into the present era is the privileging of rational and technical scientific knowledge over other forms of knowing. In this hierarchy of knowledge, to know something through one's emotional senses or from one's experiences is inferior, for this knowledge can never be proved to be correct through repeated experimental testing or strictly logical argument. Again, there is a gender dimension to these power relations as women have been mainly associated with intuitive, embodied knowledge and with the emotions while men have claimed the rational, scientific and technical forms as their own (Davis, 1997). This can help to explain the continued domination of medical knowledge and the medical profession over nursing. While many nurses are taking over some more technical forms of medical care from doctors, nursing still involves other forms of knowledge and practice associated with caring which are traditionally associated with the domestic caring duties of women, but it also entails building a relationship with patients, getting to know them as people, relating to them on an emotional level and, through this, reaching an holistic understanding of their needs and devising an individual care plan on this basis. It rests on the view that caring is not just about addressing physical symptoms, but involves setting health and illness into the context of the patient's life and attending to social, psychological and emotional factors. In this way, nursing knowledge incorporates the technical and the medical alongside the experiential and the interpersonal: to do this it draws on the natural sciences as well as the interpretative or hermeneutic social sciences. The latter are concerned with understanding the meanings and values that actions have for those who practise them, and the method of such sciences involve entering into dialogue with people in order to gain access to their world view. However, there has long been a debate in the social sciences about to what extent such hermeneutic or 'human' sciences can be regarded as science. 'Natural' scientists have often treated them as a poor cousin.

Because nursing necessarily entails such knowledge, it is often relegated to the level of a 'semi-profession'. It is argued here that this should not be the case and that the humanistic aspects of nursing practice and knowledge are essential and of high value.

Many of our findings support Schön's (1983) notion of the 'reflective practitioner' who is a professional who reflects upon their own expertise and experience in given situations in order to deliver a service to clients. This reflection-in-practice is at the heart of all professional practice, although Schön argues that most professionals who wish to retain their status may have to deny this. He also claims that we are tied to an epistemology of practice which cannot help us to explain or describe these core professional competencies. However, this research's data are rich with accounts of the experience and expertise of nurses, and the researchers feel that there is a developing language in the social sciences that helps us to understand how this figures in their practices. Recent literature on embodied practice and reflexivity allows us to better understand nursing practice and to unravel and talk about its many different aspects.

For all the talk of holism in nursing, there is often a lack of a holistic understanding of the nurse; the research reported here aims to redress this. Instead of seeing nurses as acting rationally one moment, working according to an individualised care plan, while in the next moment switching to an emotional mode of relating to the patient, nurses are seen acting as 'thinking bodies' (Ilyenkov, 1977; Burkitt, 1999). Emotions are not simply used to relate to patients but are means by which humans perceive verbal and non-verbal information as a whole – as part of a situation that can and must be grasped in its entirety – and through which people can process the different levels of information rapidly. This is what the researchers refer to when talking of intuition (Freund, 1998: 274). It is often the management of emotions in stressful situations that leads nurses to compartmentalise their thoughts from their feelings, passing them off as bodily sensations that do not register in the 'mind' as emotion (see Chapter 7). However, in other situations, nurses operate as whole persons whose practices and performances are embodied in the social spaces and social relations within which they work.

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Emotions are, then, aspects of the communicative responses to others that appear in posture, gesture, facial expression and in words. The expression or performance of emotion is always managed to some degree, because it is a fundamental aspect of the communicative process through which relationships are built and information is gathered, shared or withheld.

Because much of nurses' information and knowledge is gained through such intuitive processes, they are not always aware of how and why they know what they know. In this sense, the knowledge used in nursing can be usefully divided into what Giddens (1979; 1984) called 'practical consciousness' and 'discursive consciousness'. Practical consciousness is the knowledge we have about the world that we cannot properly explain to ourselves or to others: we can tell someone what we know but not how or why we know it. During observations and interviews on the stroke rehabilitation unit, when asked about how she had perceptively anticipated the needs of one of her patients, one nurse said, *'I don't know how I did that, 'cause I think you do a lot of things without thinking too much about them don't you'*. Also, nursing practice has remained hard to describe or analyse in detail, yet nurses themselves have no great difficulty in nursing their patients in well-resourced and supportive environments. This suggests that most nurses use a form of practical consciousness, able to do their jobs yet not always able to say exactly what skills and capacities they are employing. On the other hand, discursive consciousness relates to the knowledge and ability to practise that we can describe in detail to others, not just in terms of what we know but also of how and why we know it. Research-based practice would be a good example of discursive consciousness, where nurses can detail clearly and concisely the reasoning behind each stage of their care plan.

In situations where nurses have the opportunity to build relationships with patients, their practical sense of how to care for them is based on thought and feeling working in unison. Although no word accurately describes the unity of embodied thought and feeling, perhaps the word *intuition* comes closest. This research has found that experience is integral to intuition and that it also involves practical consciousness. Scheff (1990) claims that central to intuition is the skill of empathy, through which we learn to read the meanings of other people. This emphatic understanding is seen as working more like a hologram than a rule-bound cognitive system: it involves a grasp of the whole system of cultural meaning in which each part can be related to the whole. Only in this way can we ever really communicate with others, by understanding what they are saying in terms of the meaning of words within our culture and how those meanings apply in this particular situation. Such understanding is not an impersonal process; people bring their own experience to the task of empathising with others. For Scheff, the human ability to empathise is based in 'emotional attunement', which is central to the maintenance of social relations and interdependencies. However, mutual understanding is never guaranteed because people can misread each other's meanings or intentions, so that attunement is always to be struggled for.

By focusing on intuition and empathy, Scheff displaces cognition from its central place in the psychological theories of human action. Whereas cognitivism has relied on a model in which thought is understood as a series of inferences drawn from a set of rules, Scheff adopts Pierce's (1955) notion of *abduction*, which involves the rapid exchange between observation and imagination. This, rather than adherence to rules, is the basis of intuition. For Scheff, problem solving must have ecological validity; it is not just conducted in accordance with rules, but is appropriate to the context in which it takes place. Because most human gestures or expressions are ambiguous, understanding another person depends on the lightening-quick empathic connections formed with other people in the relevant situation. Scheff refers to 'total association' as part of the communicative and interpretative process that makes such a complex process so fast. Total association includes not only the classification of words, gestures and actions according to a cognitive classificatory scheme – which is the type of interpretation normally analysed by psychologists in artificial intelligence and cognitive science –it also includes classification by feelings, by emotions. We can often *feel* what another person is saying as clearly (or unclearly) as we can *know* what they are saying. In a conversation we often understand, or

fail to understand, how the person with whom we are speaking is feeling despite the fact this may be the opposite of what they are saying, or that they are alluding to a feeling behind their words that is verbally unexpressed.

Total association then, allows for the speed and breadth of understanding and problem solving, and makes possible the interpretation of communication, as well as problematic situations which require some novel solution that is not part of habitual action. Through emotional as well as intellectual associations, we can quickly consider a range of possible solutions to a problem, or of possible actions, forming connections between them and synthesising options. Feeling our way through these things as well as thinking them through allows us to come up with possible solutions to difficulties quickly and to sense whether or not an option is the right one. This is intuition, where we are searching all we know about our culture, all we have learned, along with our personal history and experience. It is from these searches that we often reach what appear to be instantaneous, unlaboured solutions to problems and interpretations of meaning, even though this actually involves much intellectual and emotional labour. The appearances of spontaneity, of almost magical intuition, is because much of this labour is done by the thinking body rather than self-conscious effort.

In nursing practice, then, both practical and discursive consciousness play central roles, interrelating with one another in assessment and clinical decision making (Chapter 8).

4.5 Time and space

Time and space are important concepts because social practices always take place in an oriented time and space. Time and space are never a neutral location for social activity, but are organised according to power relations, resources, practices and values. Under-resourcing and new management philosophies that emphasise the flexibility of the labour force have affected the pace and rhythm of nurses' work. However, there are also the normal demands of work to take into account and the different philosophies that underpin nursing practice in different contexts. For example, work in A&E will have a much faster pace than that in a hospice: responding to the immediate and ever-changing needs of patients in casualty is bound to have a different rhythm than the slow preparation for a death in palliative care. The philosophies devised to orient these communities of practice will also be different: in A&E there is a hard bitten, almost macho ethos of being able to deal with whatever is thrown at you, while the hospice weaves a calm and supportive network around the patient, significant others and nurses.

Yet time and space are interrelated. Nowhere is this illustrated more effectively than in the hospice, where, after a patient's death, her or his bed is left empty for up to three days so that the significant others can return to mourn. On busy hospital wards, the use of this time and space would be seen as luxuriously wasteful. In the hospice, the time during which this space is empty and unused is justified by the needs of the bereaved. Here the whole philosophy of this community of practice converges around a duration of time and a particular space: the days the deceased's bed is left empty.

Space is crucial in terms of the locations in a community of practice where certain activities take place. The researchers were alerted to this when noting that nurses had no private space; when they were distressed over an event they had to go to the sluice to cry. This is perhaps indicative of the fact that they are expected to be ever-present for the patient; always there to respond to the patient's every need. Because nurses on hospitals wards find that their community of practice is always located in a space that belongs to the patient, the control over space becomes a central issue, for it relates to the performance of the nurse and the control of information. For example, when a nurse goes to the sluice to cry, she is managing her emotions and performance as a professional: a nurse does not break down in front of the patient she is meant to be helping. Chapter 7 demonstrates that a professional nurse is expected to show that she can cope in all circumstances in order to reassure the patient that all is well. This is where the control of information is also related to the organisation of space; in front of a patient,

showing distress would indicate that something drastic was wrong. Such information would have to be concealed, by the nurse venting her emotion out of the patient's sight and earshot, and by her putting on a performance of calm reassurance.

This also means that the identity of the nurse is both constructed and continually reconstructed in time and space. This occurs in part within the community of practice where, every day, nurses reaffirm their identity through performances in which they interact with patients and co-workers. This community of practice is clearly located in space and time in the daily contexts in which nursing takes place. But the identity of nurse is also constructed in relation to the imagined community composed of core nursing values, which is not so clearly located in time and space. The imagined community may constitute itself in certain times and places, such as conferences or conventions, or may be consolidated through books, journals and magazines. Yet it remains largely outside of space and time, in the dimension of the imaginary construct. These two communities are interrelated, but one is more embedded in space and time than the other.

The identity of the nurse is therefore caught in a peculiar contrast. On the one hand, it is located in an everyday context embedded in space and time, yet on the other hand it is partly constituted in relation to an imagined community. This has to be the case, for only in this sense could we understand the claims of a stressed and overworked nurse that her working conditions are not allowing her to be a nurse. In this situation, the everyday context is not allowing her to be who she wants to be. Such instances are illustrated with details from the research throughout this text. However, the next chapter will discuss in greater detail the central ideas of imagined communities and communities of practice, showing how these concepts apply to the everyday contexts of nursing care.

5.1 Introduction

This chapter re-examines the concept of 'the community of practice' in the light of the research data. In giving this concept content as a practical and real phenomenon, its centrality to an understanding of contemporary nursing practice was extensively confirmed. The chapter provides a fuller understanding of the defining elements of a community of practice and their dynamic interaction, in effect mapping out the analytic framework for analysing the data. It presents the conceptual language which emerged from the research and is used in subsequent chapters to provide detailed accounts of the processes of nursing socialisation and the exercise of clinical judgement.

The community of practice as progressively understood through interrogation of the data has two major axes that define its essential nature (Figure 5.1); each summarises the many elements which provide the dynamic mechanisms whereby it functions in reality. One axis is defined through a social psychological sense of identity – a *consciousness of kind*; the other is made up of the interaction of resources, power, space and time in a specific setting – it is *institutional*. Although represented as independent the axes interact in shaping any nurse's experience of being a nurse. Although nursing operates through the construction of shared identities which give meaning to the status of nurse, and legitimate the act of nursing, care is delivered in a specific setting. The subjective sense of identity which frames the authenticity (Taylor, 1991) of the nurse's behaviour must operate within an institutional infrastructure, determined by distant impersonal forces operating in relation to abstract managerial concepts.

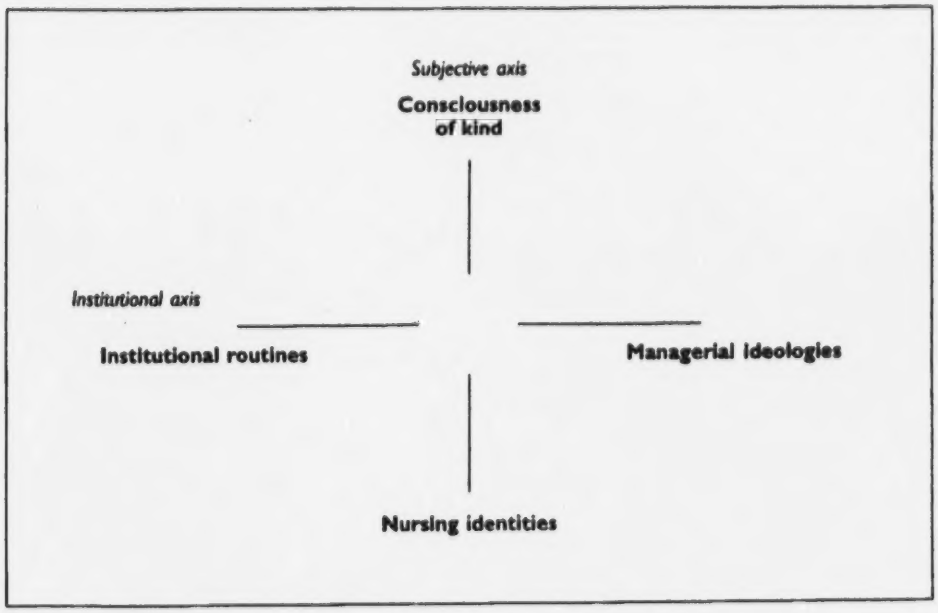

Figure 5.1: Community of practice: the institutional and subjective axes

Unpicking this model a little further illustrates that each day *every* nurse delivers nursing care in a domain over which they have little control. Its physical fabric is determined by external economic parameters and health care philosophies; some needs enjoy temporary vogue status and attract funding, while others seem to languish eternally (for example, think of adenoids and tonsils that demand removal, ECGs and organ transplants that are essential,

fertility treatments that are a luxury or essential). At a more fundamental level, access to health care may be seen as a right that the state must address (Beveridge and Old Labour) or a personal responsibility in relation to which the state may only offer a modest safety net (Thatcherism). Managerial ideologies which attend such transitions have their own economic and bureaucratic impact, in the form of such potent mantras as 'efficiency', 'cost-effectiveness', 'evidence-based practice', 'audit' and 'competence'. The robust, but myopic, logics of 'instrumental reason' links many of these agendas and contributes to an alienation of the human essence of caring from the process of nursing (Benner, 1989). Whilst nurses may use political and professional routes to attempt to shape policy agendas, the context of daily work is predominantly beyond their control.

If Government policies and economic support for health care seem distant, complex and elusive, the *context* in which nursing care is delivered is experienced directly, pervasively and intimately. The number of beds in a given space in relation to a fixed package of staff may be an abstract norm against which to measure efficiency and cost-effectiveness, but for nurses they represent a set of relationships which define their ability to provide care. When operating within these parameters they may be judged efficient and cost-effective, but this does not guarantee that nurses will be able to take pride in a job well done; they may feel unable to deliver quality care. The institutional parameters defining a community of practice provide a common structured world, shared by those working there. This is an important feature of a community of practice, for the shared institutional context is *one* basis for the formation of a shared identity.

There are sound reasons for accepting the assertion that social being determines consciousness – what we do contributes to our understanding of who and what we are. However, pre-existing conceptions of who we are means that we may have selective perception in responding to a shared environment. Indeed we may interact with that environment selectively and experience it differently. Since different professions, and nurses with differing professional identities, work within the same environments, then different shared identities are probably being rehearsed. Thus the hierarchies of professions within any clinical context have an established normative structure, and relations between these professions are embedded in contested relations of status and power. As noted in Chapter 4, these power relations are a further defining institutional feature of any community of practice; having been established over time and routinised in the culture of each workplace, they are part of its institutional framework. To the extent that these statuses and relations of power have been constructed through the formalisation and bureaucratisation of delivering care they are part of the impersonal 'iron cage' of institutional practice which define the nature and limits of nursing.

Of course these statuses also have a powerful subjective existence. Nurses are nurses; they are not social workers, doctors, pharmacists, or chaplains. Indeed they are not only nurses in a generic sense but are frequently self-determined specialists such as mental health nurses, adult nurses or paediatric nurses. These 'specialisms' are both powerful professional identities and highly defended personal identities. One achievement of nurse education is to facilitate and sustain these semi-autonomous identities; the Common Foundation Programme (CFP) is effectively the lowest common denominator of a shared generic identity, planned to be usurped by the defining boundaries of the branch. Nurse education is the vehicle for initial nurse socialisation, which becomes consolidated, or threatened, through the experience of particular communities of practice. Thus the axes of the community of practice can again be seen to powerfully interact through the institutional construction of identities defined in relations of power, and personal ownership of these social constructions as ego-involving personal identities. Since these professional statuses are part of a nurse's personal identity, the shared experience of the community of practice may reinforce these identities and the boundary markers defining them.

5.2 Community of practice: consciousness of kind

In talking of the ease with which we take the concept of nations for granted, Anderson (1981) described them as 'imagined communities'. This idea has proved almost irresistible, and has been endlessly cited. Perhaps part of its magic lies in the creative mystique of 'imagination' associated with the warm and positive connotations associated with the idea of 'community' (Husband, 1996). We shall never meet all members of our nation but we can imagine our shared characteristics and value our shared identity. These shared characteristics and common understandings amongst nurses who remain unknown to one another are reflected in one nurse's interview:

> *'It's quite a close group isn't it nurses they sort of – you're all in the same boat and you're all doing the same thing and you all know how each other feels a lot of the time.'*

In this quotation nurses can be seen as an imagined community, with a strong sense of shared values and an emotional as much as intellectual attachment to the label. Nurses, just like nations, can define themselves by their aspirations, as much as by their achievements. Like nations they develop a collective shared past, an 'invention of tradition' (Hobsbawm and Ranger, 1983), whereby through selective amnesia and the cultivation of epic events they construct a coherent and valiant past, and this shared history informs their present struggle. In sum, nurses inhabit a shared identity that is socially constructed and has a continuity expressed in its members' subjective values, practices, beliefs and emotional attachment.

But in invoking the notion of 'consciousness of kind' a deliberate insight into the range, and limits, of this imagination is intended. In trying to describe the nature of ethnicity, another shared imagined community, Wallman (1986) contrasts two dimensions of ethnicity: one being consciousness of kind and the other being structural. When people invoke their identity as Mirpuri, Yorkshire, Afro-Caribbean, or Cornish they are expressing their sense of a consciousness of kind; of wrapping their sense of *me* within a powerful shared *we*. But as Wallman reveals, if we perceived ethnicity as only consciousness of kind we would have no idea of the ease or difficulty with which people express their ethnicity in their daily life. For example a 'Pakistani' British citizen and a Bosnian refugee, both living in Bradford, might have an equally strong sense of ethnic identity, an equally valued and committed consciousness of kind: one as 'Pakistani' and the other as 'Bosnian'. However, while members of the Pakistani community find no difficulty in obtaining their preferred food, a range of media targeted at them, a range of places of worship and opportunities to use their language in a wide range of social settings, the situation for Bosnians is very different. Of course the Pakistani community has established itself over four decades, is numerous and has consequently developed the social, cultural and economic infrastructure that makes possible the lived expression of their ethnic identity (Lewis, 1994; 1997; Rex and Samad, 1996). The Bosnian community possesses none of these infrastructural advantages.

Thus, a strong consciousness of kind is no guarantee of the possibility of expressing an identity in action, nor of the survival of that identity. In exploring the practice of nursing within the communities of practice through which care is delivered, it is important to distinguish between the subjective solidarity – the consciousness of kind – which sustains nurse identities, and the institutional structures, routines and ideologies – the infrastructure – which define the boundaries of possible modes of practice.

5.3 Professional socialisation

One facet of nursing's history has been the attempt to translate the logics of the system into the values of the profession. Professional socialisation has been a complex struggle between the humanism that informs the 'vocation' to be a nurse and the instrumental reason of health service management to provide an efficient service. An intellectually coherent and

managerially compliant system is best achieved when the 'professional identity' is saturated with the managerial aspirations and ideologies of those who plan health, rather than those who deliver it. The moral imperative to care should not be confused with the 'professional' aspiration to be 'competent'. Professional ethics are collective social constructions whose aim is to define and *limit* the responsibilities of the professional (Husband, 1995); they legitimate the possible and normalise the routinely attainable. Here, the humanism at the core of the consciousness of kind of all nurses – expressed in the ethos of 'holistic individualised care' – conflicts with the pragmatic necessities of delivering care in a specific community of practice. The generosity of 'being for the other' (Bauman, 1993) does not easily reduce itself to discrete competencies or budgeterially-required clinical decision-making. The open-ended contract of being for the other, of caring, sits uncomfortably with the structural necessities of block budgets and efficiency gains. Thus the two axes of the community of practice not only interact; they may generate contradictions and conflict.

The negotiation of these contradictions and conflicts can be seen throughout this report: they are not simple and clearly bounded; they are many, nuanced and highly interactive. One major reason for this lies in the fact that the range of nursing practice is not bounded by one shared consciousness of kind. There are distinctions between branches and specialisms, and within these, hierarchical distinctions of achievement, responsibility and power. There are, for example, many answers to the conundrum 'when is a nurse not a nurse?' One species of answer starts with 'when she/he define themselves' (the variety of self-definition binds specialism and status): I'm a mental health nurse, a theatre sister, an A&E team leader, a burns nurse, a burnt-out wage slave. Another species of answer starts with a further question: 'when is a nurse a manager?' Given the pace of change within the health service and the extensive restructuring of nursing job descriptions, the fit between nursing values and nursing activity may be strained. A recent complaint by Help the Aged that 'real' nursing care is provided by nursing assistants, and the introduction of a consultant nurse scale, both illustrate the tension between delivering nursing care and managing nursing systems.

So consciousness of kind as an axis framing the community of practice cannot be homogeneous or singular. The particular identities brought to the community of practice determine the response to the structural constraints caused by the forces in the institutional axis. The data provide a rich source of insight into the structuring of identities and their negotiation. We all possess multiple identities – nurses no less than the rest of us; if they did not, the emotional work of nursing would be barely problematic. But the negotiation of identities within the workplace exists not only between a personal and professional identity, but more frequently between personal and multiple professional identities. Certainly the professional specialist identity is likely to be qualified by one's personal status within it. Specific job descriptions, and the experience gained in achieving and sustaining them, provide a distinct existential nuance to the process of sharing a consciousness of kind and inhabiting a distinct community of practice. In both the educational setting and clinical practice, interviews frequently revealed a lived and living biography. Nurses may have specific job descriptions but they live and work within communities of practice framed by both a structural history that determines their current dynamic, and a personal/professional history that gives subjective relevance and value to the 'community' the nurse experiences as relevant. Put another way, the physical properties of the community of practice cannot pre-determine the community of others – the consciousness of kind which each nurse brings with them. Nurses themselves, through job mobility and career change, often take responsibility to find a fit between their valued community of identity and a work setting which enables them to express themselves in practice.

5.4 Nurses: the inclusive identity

If branch and nursing specialisms emerge as one of the key sources of nursing identity it is equally apparent that another collective identity plays an important role in shaping nurses' relation to their work. This is an inclusive and generic identity as *a nurse*. If the CFP represents

the lowest common denominator in nursing education, it does not mean the a generic nursing identity is shed following transition into branch and later a specialism. Throughout the data there is evidence of a Promethean identity as 'nurse' which is compatible with, indeed at the core of, all nurse identities. This imagined community is the common fellowship of those called to care; it expresses itself with a fulsome commitment to holism in meeting patient needs. For example a nurse directly refers to caring as part of the generic nurse identity:

> *'I mean there's the nurturing aspect that comes into it as well. I mean we are nurses, we care and nurture people and I think when you, as much as this sounds a bit of a cliché, but when you're in the sick role, it is nice to feel cared for, have a hug, have a pat and be given alongside verbal reassurance and things, just to be given a little bit of physical reassurance.'*

However, while caring, compassion and empathy were regarded as characteristics of the generic nurse identity, this was tempered by another unique generic quality – the ability to control the emotional aspects of caring, as one nurse pointed out:

> *'Anybody can have compassion and empathy with people, and I think that that's what it's (nursing) about. But you have got to be able to control that empathy and sympathy for people and I think you cannot do that by reading about it or learning about it.'*

Another nurse similarly describes the need for nurses to control emotions:

> *'I think you've got to look in control for patients ... I mean – it's nice to share emotions with one another ... you know, if they're upset and you're upset it's nice ... for them to see that you're human as well isn't it. But you've still got to have some sort of control and they're depending on you really a lot of the time for knowing the answers and so it's good to see you're human but still knowing.'*

These complex issues of emotion and control, discussed in more detail in Chapter 7, often lead to nurses divorcing their bodily feelings from cognate experience of emotions. However, this is a temporary tactical phenomenon, as nurses primarily aspire to work as embodied, reflective practitioners. The researchers initially anticipated finding a Cartesian, mind-body dualism in nurses' general perception of their practice; these data refuted such a hypothesis. If nursing has a theme, it is that 'we provide individualised holistic care'. In speaking of their work, they may invoke particular models of nursing, but these are complementary to, not an alternative to this creed.

If earlier it was rather glibly asserted that nurses are not doctors or social workers or pharmacists, now is the time to reassert this as the product of an active social psychological dynamic. From symbolic interactionism (Mead, 1932) to social identity theory (Robinson, 1996; Turner, 1987) there is an acceptance that in-group identity is partially constructed in relation to comparison with targeted 'out-groups'. These out-groups are never random and their purpose is to provide a *psychologically* rewarding boundary between self and other: between us and them. As social identity theory argues, social comparison between self and other routinely aspires to provide positive feedback to self; to make us feel good about ourselves. Where out-groups have the power to make us feel inferior or bad we have a rich array of socially creative strategies which seek to provide a psychological escape from the experience (Turner, 1987). The medical profession has long provided nurses with such an out-group, and currently health care managers provide a highly rewarding out-group (Traynor, 1999).

In-group/out-group dynamics were evident amongst various groups throughout the data. For example, on one elderly psychiatric ward there was considerable friction between nursing and medical staff. Contrary to observations, medics accused nurses of not delivering psychological care, whilst medics were apparently withholding information about patient care. The nurses' work was expected to be oriented around the medics' time, to the extent where they

had to terminate patient handovers to speak to a doctor who would not wait. The breakdown in communication was exacerbated by medics trying to dictate when and where nurses took refreshments, which was resented by the nurses. The in-group (nurses) and out-group (medics) dynamics were overt, with both public and private complaints of the other group. This resulted in the nursing team, itself comprised of conflicting personalities, being strongly unified in their resentment towards the medics. This issue of in-group/out-group dynamics also relates to power relations as illustrated in Chapter 4.

Members of out-groups are also rounded human beings with many abilities, values and characteristics. However, it is the nature of intergroup behaviour that only specific facets of their identity become the basis for social comparison. These *criterial attributes* upon which comparisons are made do not emerge at random – they constitute the boundary between 'us' and 'them'; for example, adherence to the medical model is perceived as a major determining difference between nurses and doctors. Nursing in this generic sense clearly also values a shared body of knowledge and skills. Others may diagnose, offer pills or ensure a viable fabric of social care; but nurses nurse.

Suffused throughout this community of nurses is a shared belief in a personal engagement with the patient. Emotional labour may be a feature of such nursing; but it is a valued challenge, not a burden. Technical proficiency would never suffice for this body of workers. Caring is intrinsic to their work and they are dismissive of health care professionals they believe either explicitly seek to distance themselves from the patient, or whose mode of operation means they have little opportunity for meaningful interaction with the patient. The most powerful expression of this shared value within nursing as a generic identity is ironically found in nurses' mobility from one area of nursing to another. This generic identity as 'nurse' not only expresses itself in the policing of boundaries between nurses and other professions, it is also vividly present as nurses leave communities of practice which inhibit their lived expression of this identity and move toward ones which empower it.

This consciousness of kind as *nurse* enables nurses working in different settings to share the joys, frustrations and failures of their practice. Whilst not necessarily sharing experience of ITU, mental health nursing, A&E or palliative care they possess a shared system of values, and out-groups, that provide a common language through which they can share their practice. Marginalised in their pay, undergoing frequent and sometimes inexplicable job restructuring, finding work-related stress endemic and knowing that it is possible, as many have done, to leave; these things are shared by nurses in the sample. But these shared *experiences* take on shared *meaning* as nurses working in very different settings seek to negotiate and sustain a shared consciousness of kind: that of 'nurse'.

5.4.1 Nurses as specialists: embedded identities

From both educational and clinical settings, the data reveal distinct and highly-valued specialist identities *within* nursing. These too provide strong communities of identity with well-developed in-group and out-group dynamics. Specialist nurses can form a strong, cohesive identity around their area of practice. However, nurses who attempt to work in these areas and are deemed unable to 'hack it' or not to have the specific, often unarticulated qualities of the specialist, can effectively be ejected from the area. For example to be an A&E nurse you had to be a 'crack-pot' with a gallows sense of humour; A&E nurses also described themselves as 'hard' under certain circumstances. One stated that *'we're not your caring brow-mopping nurses'*.

However, this is not to say that A&E nurses were emotionless automata; nursing in A&E requires highly skilled, complex management of emotional states. It could be argued therefore that a nurse who was too intense, serious or emotionally labile would not fit in with the specialist identity within A&E nursing.

The consciousness of kind here is typically of a community of practice that carries a specialist title, such as A&E nurse. By definition, for those who identified themselves as specialist

nurses in the fieldwork and interviews, their specialism was defined by the context in which they worked. Thus the community of practice encompassed other professions who formed part of the permanent, stable workforce. In these areas there was a more flattened, heterarchical relationship between employees. For example, on one acute psychiatric ward, not only did nurses attend the traditional ward round, but doctors also attended the nurses' handover. Treatment decisions in this and other settings such as the hospice, community mental health and A&E were negotiated. These communities of practice did not just include professionals, but also clerical and ancillary workers as valued members; for example in A&E, a distressed mother was comforted by the cleaner. This was not just any cleaner, but the 'A&E cleaner', part of the A&E family.

Nor is this identity solely a function of the social psychological dynamics arising from a shared professional identity. In a way that is entirely supportive of the model of community of practice sketched in this chapter, it is also equally clear that these distinct identities are shaped and given meaning by the structural determinants of their particular community of practice. A&E is typically characterised by a rapid flow of patients, and time pressures constantly underlining the engagement with them; in contrast, palliative care assumes a different framing of nurse contact with the patient that assumes an absence of time pressures or the constraining immediacy of space and resources on a surgical ward. Thus these communities of identity of *nurse as specialist* are defined and negotiated through the interaction of the particular institutionally-determined structural features of the workplace and the dominant criterial attributes of this imagined community of colleagues.

This interaction is discussed more fully below. However, it is appropriate first to examine the relation between these specialist identities and the generic identity of 'nurse'. As already suggested, a powerful insight into this relationship was revealed through nurses' accounts of their mobility within the profession. This movement from post to post was frequently not a simple act of self-serving careerism; it may often be driven by a desire to relocate to a professional context where institutional parameters are more conducive to the expression of those values that define 'the nurse' in its generic sense.

This form of mobility is not merely an indication of egoism (selfish-individualism) among nurses, but should more accurately be seen as an active attempt to pursue a sense of personal authenticity in practising as a nurse. As Taylor (1991; 1989) has argued, contemporary individualism can take a deviant turn toward selfish narcissism: a placing of self-interest at the centre of social action and an entirely inward looking commitment to 'self-determining freedom'. This freedom is fundamentally egocentric and all the more so when sustained by a moral subjectivism in which a rejection of external values is seen as consistent *with being true to oneself.* This form of individualism apparently invokes a concern with authenticity, being true to one's values, but as Taylor demonstrates it is a perversion of authenticity: *'The self-centred forms are deviant, as we saw, in two respects. They tend to centre fulfilment on the individual, making his or her affiliations purely instrumental; they push, in other words, to a social atomism. And they tend to see fulfilment as just of the self, neglecting or delegitimating the demands that come from beyond our own desires or aspirations, be they from history, tradition, society, nature or God'* (Taylor, 1991: 58).

The nursing professions are not insulated from this egoistic individualism amongst their members. Some entrants into nursing disclaim any 'vocation' in their choice of profession; in that context nursing is a viable career option offering relatively easy entry, likely continuity of employment and a transparent career structure. Their pragmatism toward 'a career' in nursing may also serve them well in adapting to, or adopting, the instrumental reason that informs much of the health care system. In that sense their personal values would potentially fit adequately with significant elements of the institutional axis of their community of practice. They may even go far. However, they may simultaneously find themselves at odds with the dominant beliefs and values of the community of identity.

An observation with one nurse illustrates how moving up the career ladder can result in moving away from the 'nurse' identity within a community of practice. An acting F grade had to renegotiate her place back into the 'core team', and at the outset of her period in management she experienced a difficult period of adjustment. First she identified herself as one of the nursing team, classifying herself as a good clinical practitioner. She continued practising at a full-time participative level, leaving management and administration to when the ward was quiet. After a while nurses started to complain that their jobs were getting harder and 'standards' were falling. Consequently she concentrated more time on and gave more value to managing the ward. This shift from the community of practice of the 'hands-on' workforce to a more managerial role caused considerable dissension in the staff. Having effectively left the core team, this nurse now faced 're-entry' into it. She described her struggle negotiating her new role:

> *'It was hard for me to convert from being totally hands on and doing everything to pulling away ... But when you're in a sister's post you seem to, I, well maybe it's because of the way I am or not I don't know, some people I think feel that it distances them from the staff but to me it didn't really'.*

Within this quote is the inference that there is a marked difference in perception of how central to the staff the newly-appointed sister is. Her team feels she is distant, yet she clearly believes she is not. This demonstrates the fragility of membership in the community of practice and how movement up the career ladder can compromise that membership, leaving the nurse in a more peripheral position. The contemporary tension between the competing values of nursing and management may exacerbate this process (Traynor, 1999).

This same nurse described how she had frequently moved jobs to advance her career leaving people behind with apparent ease:

> *'Because I've moved loads of times, you know. It doesn't bother me moving, I'd move tomorrow, I wouldn't be heart broken. You know, I be upset to leave them behind but you know, it doesn't bother me'.*

To the extent that the generic identity of 'nurse' is embedded within the core values of all specialist identities in nursing, this egotistic pragmatism will make nurses such as the one above marginal to the consciousness of kind which informs their community of practice. They can become successful but not liked, 'efficient' but not respected.

Indeed the usual profile emerging from within the data is of nurses imbued by a concern with a pursuit of authenticity which engages each individual in a shared negotiation of common values. This variant of contemporary individualism acknowledges the powerful ideology of being true to oneself – but it is a self that is inherently social, that knows itself through committed interaction with others (Taylor, 1991). This is a commitment to authenticity that finds positive reinforcement and fulfilment in being expressed within a community of practice. Consciousness of kind is necessarily social, interactive and a process in negotiation rather than an established fact. The data strongly suggest that the identity of the generic nurse sets the horizons that guide specialist nurses in living their distinct identity. Their subjective pursuit of authenticity finds behavioural expression as each nurse seeks to equate their practice with their shared identity. Where institutional constraints within a particular community of practice inhibit nurses' ability to provide quality nursing they find this deeply distressing. One response to institutional constraints, is 'cognitive creativity' within the community of practice, which enables the group to survive within the *status quo*. The other response is mobility: to exit from the distressing and unacceptable environment to one where positive self-regard can be sustained through matching values with practice (Turner, 1987).

Interviews with, for example, teaching staff and nurses in both palliative care and burns nursing revealed exactly this active pursuit of the community of practice that facilitates

the delivery of high quality nursing. In palliative care the whole ethos of practice is holistic in its engagement with the patient as a social being whose family are partners in care and subjects of concern within the embrace of the caring management of death.

Within this vision of palliative nursing, time emerges as a central structural feature of the community of practice. With the immediacies of A&E routinely absent and the trajectories of 'cure' suspended, the quality of the patient's time shapes the construction of time in the workplace. Time is created for the delivery of care, and remarkably for the collective negotiation of death, with the bed left empty for two days to allow staff and family to mark the patient's passing. This structural facilitation of caring would seem absurd or perverse on the typical surgical ward. Not surprisingly specialist palliative care staff speak positively about this community of practice and speak of moving into that area of practice because it allows them to nurse as they believe nurses should:

> **Nurse:** *'It was a lot slower pace at the hospice, there were more nurses to patients at a ratio and you just had more time to give them and stay with the patients.'*
>
> **Researcher:** *'Right … So you were able to deliver more the care that you wanted to give.'*
>
> **Nurse:** *'The care that I wanted to give and the care that I was more used to giving.'*

Another nurse from the hospice described similar motivations driving her choice of practice area:

> **Nurse:** *'Coming back here I found it as I had remembered nursing.'*
>
> **Researcher:** *'Which was how?'*
>
> **Nurse:** *'Well … I don't know really how to describe it. There was more basic nursing, bed bathing, general care for patients. Very little machinery really … and I just found it was more here, a lot of caring for the patients and their families and good sort of nursing, bed bathing and I can sit and talk to patients and I felt … Well I felt my skills as a – having been a mother of three children, you know, I found that was helpful. I think a lot of it is just basically experience of life … I wanted to come back and do something I liked – I enjoyed doing.'*

For the nurses who chose to work in palliative care, their decision was underpinned by having the time and resources to deliver 'good, low level, basic care', care that was akin to their values of nursing.

Nurses who chose to work in a burns unit were equally explicit that this is a desirable specialism precisely because of the quality of nursing they were able to deliver. For them the extremis of many patients, and the implications of their injuries for an altered bodily consciousness of themselves, demand a degree and continuity of caring that is rewarding. Adequate caring in these circumstances requires an essential minimum of infrastructural support that is seen as less negotiable than, say the support essential to community mental health. Burns units are traumatic and necessitate an intensity of nursing and resources if they are going to have acceptable levels of efficiency in terms of outcomes. These medical and managerial parameters generate a physical community of practice, that whilst stressful, is also fulfilling.

Thus authenticity, as an individual's commitment in being true to themselves in relating their own practice to their shared values as nurses, is a powerful sub-stratum underpinning the coherence of different specialisms. The stress of seeking to sustain this authenticity is so considerable in some areas of nursing that one option exercised by nurses is that of exit. For some this is from the profession altogether; either burnt out or acutely disenchanted with what they see as a national compromise over nursing standards they choose to leave. For them a

vocation undermined is a vocation denied; and consequently also a profession that merits their leaving. However, the different structural circumstances characterising some communities of practice make them sites where nurses can equate their values with practice. Their sense of fulfilment in achieving this powerfully feeds into their strong attachment to these professional locations and the specialisms within them. With all the enthusiasm of converts, nurses who have moved into such specialisms, sometimes via a loss of seniority and income, speak eloquently of their community of practice. Theirs is a valued in-group, and often all the more strongly defended because of their prior knowledge of 'inferior' out-groups.

5.5 Surviving the contradictions: nursing values in a hostile environment

Although mobility within the profession is one means whereby nurses can sustain their sense of personal authenticity, this option is not open to all. The robust expression of health care needs emanating from the medical profession, health lobbies and the public is not matched by the resources available. The tight budgetary constraints within the NHS has resulted in extensive attempts to generate 'efficiency gains', resulting in, among other things, restructuring and a diminution of staff within many communities of practice. The institutional axis determining the characteristics of a community of practice is therefore not only powerful, but often produces a truly inadequate infrastructure for the delivery of care.

Where student nurses are essential to the basic operation of a ward, their student status is compromised by the responsibilities they are expected to fulfil. Where staff numbers are low and patient throughput high, the time available to senior staff for mentoring nurses or students is limited and pressurised. Where through clinical audit and the implementation of evidence-based practice nurses are aware of their external accountability to managerial systems, as well as professionally committed to the immediate needs of their patients, they may resent the pressures under which they work. Stress generated by resourcing and staffing levels was identified as an issue in all clinical areas studied, except the hospice. The project thus confirms nurses' common experience that the characteristics of their community of practice are effectively over-determined by the institutional forces defining their workplace.

The contradictions between their identity as nurses and the compromises necessitated by the institutional environment are stressful and potentially damaging to the individual, and dysfunctional to the delivery of care. Thus, if emotional labour is a necessary product of the relationship between self and patient in the delivery of care, so too 'social creativity' is a necessary activity of negotiating the subjective consciousness of kind of 'nurse' with the institutional characteristics of a specific community of practice. Here the genesis of some specialist nursing identities can be identified.

If some specialist identities derive value for their members because of the considerable extent to which their community of practice enables them to express the values of the 'generic nurse', perhaps some acquire a valued specialist identity through the collective construction of the compromise with these generic values that is essential to survive there. For example, in both A&E and the surgical ward it was apparent that the number of patients and the rate of turnover constitute a direct challenge to the nurses. The staff:patient ratio and nursing tasks to be accomplished make both sites challenging. The time to be spent with one patient must be defended against the simultaneous demands of others. A prime example of this negotiation of multiple demands comes from observations on a medical ward, where an elderly patient repeatedly demanded attention from nurses, to the point where the care of other patients was threatened. This resulted in the nurses having to juggle the sympathetic care of this particularly anxious patient with the needs of all the others.

As noted in Chapter 4, in all settings there is a hierarchical structure which operates among the nursing staff, and between them and other professions. Even in the seemingly most egalitarian structures, power relations in the community of practice were evident. Importantly

this hierarchy is also integral to the routine collective shaping of clinical judgement and the practical delivery of care. In other words, it represents not only some form of personal merit, it is also a badge of institutional power: such that colleagues who may not attract personal respect may none-the-less exercise institutionally-legitimised power. The working environment of these communities of practice are highly constrained by those forces, which seriously challenge nurses' ability to deliver the service they might wish. For example on one ward an ambulance crew arrived to take a patient home, but refused to take the patient because (they said) the nurses did not book an ambulance with a tail lift and there was no room for his wheelchair. Fortunately the ward clerk produced a copy of the requisition with these details clearly marked. Rather than contacting their line managers, the ambulance crew decided to go for a coffee, leaving the ward clerk and the nurses to resolve the situation. Not only would they not take the patient, neither would they take anyone else in his place nor speak to their controller who made the error in the first place.

One response to these constraints is to resolve the contradiction by a suspension of nursing values. Hierarchical forces that resulted in the suspension of nursing values were observed infrequently and were accompanied by other influential factors such as power relations. For example, one patient's terminal diagnosis was kept from him, despite his frequent requests for his histology results. Every member of staff knew his diagnosis, but only the consultant could tell him, immediately prior to his discharge. The power and position of the medical staff effectively silenced the nurses' voice, so the community of practice colluded in keeping the patient in the dark.

We also see here a case of 'blaming the system' or an individual (in this case the consultant) for making 'nursing' impossible. In such an instance it becomes possible to accept the dominant *technical tasks* required of that community of practice as the effective criteria of professional adequacy. This was witnessed during observations with Project 2000 students. One student distributed drinks faster than anyone else, completed vital sign observations faster than anyone else, in short, got the work done! However, she was unable to respond to a patient crying outside of a task-oriented model; patient crying, therefore she must be in pain, therefore I'll give her analgesia. Amongst the ward staff however she was perceived as a good nurse, i.e. efficient and hard working.

The efficient exercise of professional competencies in a pragmatic manner, within an externally-defined caring regimen, can thus remove the moral ambiguity and professional anguish of negotiating a relationship between the institutionally-defined demands of this site of practice and a deeply held professional identity. This professional form of 'truanting in the mind' allows the nurse to participate in the community of practice without identifying with it. In effect, core elements of the subjective axis of the community of practice are neutralised and its perceived identity is institutionally determined and impersonal.

There is little evidence of this response within our data. The more familiar response is what was referred to in Chapter 4 as 'virtuoso performances', a form of social creativity in which nurses working under duress sought to optimise their ability to operate as good 'nurses' despite contradictory infrastructural constraints. The skills required to successfully negotiate this strategy consequently became important *criterial attributes* for this in-group identity. Putting it in blunt phrases which reveal something of this psychology, one could imagine such nurses saying 'It's easy to be a "good nurse" in palliative care – but it takes real resilience and skill to be one here'. Thus specialist identities that are constructed around particular communities of practice still fully subscribe to the core identity of the generic nurse. However, they find their particular consciousness of kind in the shared techniques of accommodation to their environment that allow them to preserve that commitment, despite the brutal external forces. This accommodation necessarily involves an acceptance that at the behavioural level it is simply not possible to do all that you might wish. But because of, rather than in spite of this, collective pride is created through the 'appropriate' identification of priorities. For nurses in these sites it

is an expression of real nursing skill to establish high standards of clinical judgement by eliminating the desirable and defending the essential. As a consequence, there is a complementary development of a shared practice that employs a highly integrated meshing of demarcated nursing tasks. Given the pressured environment, such interdependence is both essential and fragile. Social psychology indicates that when groups are under external pressure they tend to have stronger in-group discipline and closer adherence to in-group norms.

This stronger in-group discipline is particularly important in highly pressured situations such as the potentially life-threatening events encountered in A&E, where roles are strictly defined and articulated:

> *'Yes I think when you have done it a long time and work in a team like we work in here everyone knows their role in a team. And we define that role at the beginning of every shift. If we get a trauma, who's doing what in the team so everyone knows at the start what their role is. And they do that role and we don't deviate from that, because if you start interfering with somebody else's role things get missed. People think somebody else has done it.'*

> *'Well we try to work as a team that is the criteria of it [A&E nursing]. Nobody works separately. Although we are all working as individuals we are all integrating our skills and working as a team.'*

It is perhaps not surprising then that in such communities of practice, authority is more visibly structured within the working setting. However, real interdependence and in-group discipline provide a material experience of professional coherence that feeds a distinctive consciousness of kind.

The routine verbal rehearsal of shared external stressors and the unambiguous awareness that everyone's contribution is a necessary part of the whole contributes to an appreciation of the vital role of team *ésprit* in keeping the whole unlikely edifice afloat. There is something of a paradoxical construction of morale through acknowledging how central morale is to surviving nursing in a hostile environment. There is something here of the psychology of 'We few, we precious few'.

5.6 Stress and coping in communities of practice

The consciousness of kind operating in communities of practice like those studied is to a significant extent informed by a living sense of fragility. One locus of this fragility is the precariousness of care delivery. In a service under stress there is a realistic awareness of how narrow are the margins between good nursing and incompetence. A colleague's absence through illness, a new colleague to be weaned into the team, or a sudden overload of patients can all be sufficient to switch stress to crisis: to convert finely-balanced coherence in the community of practice to *ad hoc* making do. The importance of the patient as central to the models of care gives a strong emotional edge to this awareness of the fragility of care. The institution has the lowest salience as a variable in the nurses' sense of their responsibility in delivering care, despite the fact that the institutional management system has routine mechanisms for monitoring their performance, and has means for holding them accountable for inadequate care delivery. That after all *is* part of the collectively-rehearsed, externally-defined, institutional axis of their community of practice. But in the participant observation of practice and in the interviews a commitment to 'the patient' emerges as recurrently central to their experience of nursing. Thus the fragility of care delivery is not just an issue because it hovers on the edge of professional incompetence as judged by external audit.

This research suggests that the stress arising from the routine fragility of care delivery lies in its more fundamental threat to the nurse's commitment to the patient. This view is

further supported by interview data in which patients and their family emerge as the most ubiquitous source of stress across all communities of practice. If they were not given significance by the nurses, their presence could be effectively discounted in the context of the many other forces impacting upon nurses.

The core role of institutional processes and related issues of staffing and resourcing as key structural determinants of the community of practice have already been noted as sources of stress within the interview data. Interestingly the demands of other professionals and the multiple roles that a nurse may need to play within a community of practice are also sources of stress. The fact that ***both*** these sources of stress emerge as significantly present in only mental health nursing and rehabilitation at least suggests that communities of practice requiring routine inter-agency working may be particularly stressful in that they require the meshing of autonomous professional cultures. The fact that neither A&E nor the surgical staff reported role conflict as an issue further suggests that strong external pressure may be matched by clear in-group identities; bounded by a particularly clear expression of authority.

It is apparent that in different communities of practice this sustained sense of living on the edge of professional adequacy can vary dramatically. The urgency attached to diagnosis and treatment, and the sheer pressure of patient numbers makes A&E particularly stressful. In comparison the longer anticipated caring relationship that operates within mental health nursing, in conjunction with not always optimistic prognoses, associated with stretched resources in an interprofessional, inter-agency service brings particular stresses to community mental health nursing. Perhaps only in the hospice is there a resource base that makes the delivery of care more secure; even there the demands of the patient and family emerge as a source of stress. The aspirations of 'the good nurse' to deliver quality care leaves nurses ever vulnerable to patient demand. The normative sense of this fragility of care delivery thus is constructed differently from the circumstances peculiar to each own workplace. It is integral to the shared experience that informs their consciousness of kind as a distinct community of practice.

A second locus of the fragility that can be found within the experience of nursing is related to this first patient-orientated concern with the precariousness of care delivery. This is the more personal and existential complement to the first, and is related to the fragility of maintaining authenticity. The credibility, the sustainability, of the accommodation of nursing values with the determining structural constraints of the work place is an achievement that cannot be taken for granted. It is a struggle against doubt and dismay which must be fought continuously.

Thus, whilst post-registration education may provide an updating of knowledge and skills, it is also a relief from the front line. It is an opportunity to bond with others of your kind, and to reaffirm the faith. Nurses spoke powerfully of the enduring personal support they found in the networks created through such programmes. The physical and emotional stresses of the workplace can be shared and the professional terrain of their specialist identity can be traced to locations unvisited. The imagined community is confirmed as valid and the criterial attributes of their common identity can be rehearsed in shared activity. Not least among these activities, the perceived threats to health, commitment and competence of the physical and emotional demands of their workplace are confirmed as real: real, but with care manageable.

In clinical settings it was also apparent that within each community of practice this threat to self was a recognised hazard. Perhaps in the immediacy of the work setting it is, however, not so easily accepted as an explicit element in the daily discourse. Particularly where emotional work has an established etiquette of masking the threat to 'professional' presentation of self, an issue arising from implacable external forces is not easily neutralised. An explicit response to the *causes* of this predicament would necessitate nurses moving to a highly politicised stance. They would have to confront managers with their collusion with Government, and to loudly challenge the rhetoric that has facilitated their professional exposure to failing patients' legitimate expectations. They might even have to reinterpret their relationship to patients and

become their advocates as well as their carers. All that would run counter to the contemporary construction of 'professionalism' in nursing. Consequently, the individualism at the heart of the pursuit of authenticity is quite consistent with the profession's concern with individual competence and accountability. Appropriate workplace responses to this sense of fragile identity are therefore negotiated through predominantly interpersonal strategies that have been normalised within the community of practice.

Thus, given the pronounced pressures operating within contemporary health care, and these two strands of professional fragility operating within nursing, it is not surprising that the cultures of communities of practice are rich in collective coping strategies. Humour, as in nursing generally, is a shared means of relieving tension and expressing in acceptable code those formally unspeakable doubts and anxieties. In many settings, the nursing handover was used to reinforce the cohesion of the community of practice. Handovers were a forum in which humour was used to relieve guilt related to judgemental attitudes and negative emotions about patients. By using a 'safe' environment to air these views and emotions, the nurses also had the opportunity to clarify that others felt the same, thus relieving anxieties about owning the feelings themselves. Judgemental attitudes were therefore shared and owned by the community of practice, not the individual. This sharing of more negative feelings and thoughts, whilst absolving individual ownership, also enabled the avoidance of active confrontation of judgements and prejudices by the individual.

Another way of masking stress is by putting on a brave face, which is of course consistent with the 'can-do' ethos of nursing. Being front stage, having to mask negative feelings and put on a performance for their audience was another feature of the generic nurse identity:

> *'No matter how stressed and harassed or hard worked you feel, you know, you've always to be courteous to people. It's one of those jobs isn't it, it's like working in a restaurant or something like that, you know.'*

However, coping through sharing one's stress with others in the community of practice is even more prevalent. This suggests that a shared understanding of the awesome demands of nursing also facilitates a collegiate willingness to support each other in coping, often to the exclusion of others. For example the high level of emotion shared by the A&E team contributes to the cohesion of the community of practice, tightening it to the exclusion of outsiders. The trust taking part in the research had encouraged A&E staff to have the input of psychologists following major accidents. This was strongly resisted by the staff, who believed the best form of support was from each other; in other words only people who had directly shared the experience could understand. The tight cohesion of such a team therefore makes it difficult for individuals to integrate themselves into it as an outsider unless they were going to form part of the permanent community of practice. A similar phenomenon was witnessed in the hospice, where nursing staff resisted supportive input from the chaplain, again preferring to contain the management of distressing deaths within the community of practice:

> *'Well we do support each other. We don't need – it's like the vicars and ministers have tried to say "do you want meetings?" and we don't, we find that we do it amongst ourselves. I mean when Carol was upset the other day, you know, I hugged [her] and I took her home.'*

Actively seeking the support of colleagues was a highly visible strategy across a range of communities of practice. However, the strength of support gained was extended beyond the spatio-temporal confines of the workplace, so that thoughts and feelings could be shared with friends (i.e. colleagues) who understood:

> *'But I mean with the staff, we've always been able to talk to each other and you know, say something to each other or we phone each other up at home and I suppose you talk it through with, you know your friends really, because you can't really take it home.'*

'I think friends that are nurses that I meet outside work, you know, you have all your moans to them about everything and that's enough for me. I can ring somebody up and say do you want to meet for a cuppa after work and have a good moan about everything and everybody and then I'm alright. Then I can go home and think that's it now, I'm alright.'

Strategies for dealing with stress and highly emotive situations are discussed further in Chapter 7. These strategies may, and frequently do, have behavioural complements that impact upon colleagues. A fulsome cathartic act of ventilation may be all too evident for colleagues in the vicinity, but as one nurse describes this ventilation of anger, stress or frustration can be accommodated:

'But you know who sort of blows their top and you know that they'll come down again later and they're quite alright ... Gail needs to have like a ... release every now and again of what we sort of call stress. But like when you get to know her she's very harmless and she's fine.'

Equally, one colleague switching from emotional engagement to 'clinical detachment' may leave a co-worker emotionally exposed if in a traumatic setting they remain emotionally committed. Even seeking the support of colleagues, which signals the interdependence of the community of practice, may be perceived to drift toward dependence and a shirking of responsibility if employed too frequently. Thus, individual coping strategies have a shared normative range, and individuals who become overly dependent upon them, or fixated in a ritualised use of one in particular, are likely to be regarded as deviant.

Arguably, such coping strategies are valued as aides to continued participation in the community of practice, not as personal crutches to survival in the job. To refer back to Section 5.4, exit from the unfulfilling and over-stressed workplace through job mobility is a recognised and legitimate option. However, it is arguable that to leave the profession because you are unable to be 'a good nurse' not only preserves your authenticity, it is a positive expression of it, while to leave because you have been overwhelmed by the stresses is, to a painful degree, to be seen to have failed in the eyes of those who remain, for the ethos that binds all coping strategies is that stresses can be managed, the structural imperatives determining your community of practice can be subverted. An ability to cope is an assumed prerequisite of an ability to care.

5.7 Conclusion

This chapter has demonstrated that the community of practice is a dynamic and complex phenomenon. The relatively autonomous but powerfully interactive subjective and structural axes that constitute the essence of a community of practice have revealed the quite specific determination of working environments. The delivery of nursing care and the exercise of clinical judgement take place in contexts where nurses are striving to sustain professional identities through their practice. The structural conditions that define the context of this professional praxis generate particular constraints, the negotiation of which is a collective process. That negotiation is typically stressful, often continuing stress management as a way of life, rather than a temporary necessity, and usually a multi-layered process employing more than one strategy. The following chapters describe these processes in more detail.

6.1 Introduction

As demonstrated in Chapter 5, the concept of 'communities of practices' provides a framework for understanding nurses' socialisation into clinical practice. The two axes of nursing identities negotiated through a consciousness of kind, and of institutional structures and their regulation of resources and power, were seen to interact to shape the specific nature of the communities of practice inhabited by each nurse. So too in the educational setting these axes reveal the dynamics through which nurse educators deliver education and contribute to the professional socialisation of the next generation of nurses. As discussed in Chapter 2, the development of nursing as a profession, and nurse education as an institutional practice, has a long history and a peculiarly turbulent recent history. The current location of nurse education within the university system has added some distinct institutional pressures into this working environment.

In the case study institution within this research the interaction of the structural constraints, determined by the forces present in the institutional axes, can be seen vividly as interacting with, and being negotiated through, the specialist identities present within the workforce. In individual interviews the personal understanding of how their own teaching contributes to the production of a new nurse continues to reveal the entwining aspirations of producing the inclusive identity of 'nurse' ('one of us all') and of the embedded identity of the specialist nurse ('one like me'). This is apparent at both pre- and post-registration levels. The broad context which frames this process is the university of late 1990s Britain. This is the immediate institutional context that shapes the communities of practice of those interviewed, and is an appropriate place to start.

6.2 The university as institutional axis

Over the last two decades, British universities have experienced a radical, often traumatic, transition in funding bases, regulation and accountability, and indeed public esteem. Accused of being overly detached from the 'real world' their 'academic' priorities have been perceived by successive governments as self-serving and indulgent. Through the prism of Conservative Party neo-liberal economic ideology, universities were seen as too dependent upon the 'nanny state', and their management too removed from a realistic engagement with market forces. Progressively, and unsubtly, universities have been required to attract non-governmental funding, address the 'needs of the country' and adopt a strong vocational agenda. As a corollary of this process the unit of resource (funding) for each student has significantly decreased.

British universities are now commercial enterprises suffused with a managerial ideology that has adopted the language of corporate enterprise. Members of staff become units of cost, departments and schools are cost centres and performance indicators have proliferated and become routine elements of appraisal and decision-making. These internal languages and practices are given legitimacy and bite by the external auditing of educational and research performance by the Higher Education Funding Council for England's (HEFCE) teaching quality assessments (TQA, now QAA), and successive research assessment exercises (RAE). British universities are now lean and efficient businesses; they compete with each other for resources and esteem, and further efficiencies are routinely expected of those working within them. This is a system in which staff workloads have increased, a sense of surveillance and pressure to meet performance targets contributes to individual stress, and managers have few resources with which to ease individual burdens or facilitate non-essential activities.

Nurse education has relatively recently entered this system. The educational institution in this study shares many characteristics with newly-integrated nursing departments throughout the country. Long-established lecturers have experienced three organisational mergers in the last decade: the merger of schools of nursing to create colleges of nursing, a further merger of these colleges to create one large institution, and finally integration of this institution into the local university, where it became a school. Since integration with the university, pre- and post-registration education provision has been adjusted to fulfil the university requirements for academic award.

Although it was rarely addressed by the sample, the entry of nurse education into the university system has introduced an additional, and for many staff potentially novel, stress into their workplace – the RAE. All university staff have traditionally been expected to engage in scholarship and research. In the new era of performance indicators this has been formalised into explicit criteria of *inter alia* publication in specified journals and scholarly monographs, demonstrable success in attracting external research funds, and international visibility in the appropriate field.

The linking of funding to RAE performance, and of prestige to RAE scores, has had a dramatic impact upon the internal appraisal of individual lecturers. The pressure to achieve a high RAE score and the stigma attached to being 'non-research active' have changed the managerial and interpersonal dynamics within individual university departments – and between departments within the same university. For lecturers transferred from colleges of nursing into university departments this has produced a distinct set of demands. Having operated within a system in which research and publication was valued and respected, but largely optional, the demands of being 'research active' can be alien and threatening. The managerial pragmatics of nurturing the 'research stars' and facilitating the 'potentially research active' places immediate pressures to 'produce the goods' on those so designated. It also does little to promote collegiate cohesion with colleagues who are deemed to be 'non-research active'.

For schools of nursing, which have not had a vigorous research culture as part of their community of practice, these consequences of the prioritisation of research productivity can be disruptive of a common ownership of, and participation in, the delivery of a shared curriculum. Where, as in the school studied, the school admits student cohorts throughout the year to fulfil its contractual obligations, teaching contact is ongoing; this, and the obligations of clinical liaison, cut deeply into the individual lecturers' potential time for research. Consequently by both history and current terms of employment, nurse academics may find themselves profoundly compromised when trying to conform to the institutional demands for research excellence.

In sum, the above characteristics set this school, and many in other institutions, apart from others in the university. In order to remain viable the school must remain sensitive to the requirements of external contracting agencies and statutory bodies, accommodate the sensitivities of those clinical settings so crucial to their educational purpose, and adapt to the institutional regime and rules of scholarly production imposed by the university. Achieving this balance generates tension.

Section 6.3 traces how these institutional features shape the negotiation of nursing identities in the pre-registration, Project 2000 team. It illustrates in more detail how communities of practice operate within the educational setting.

6.3 Developing and delivering the curriculum

6.3.1 The intersection of institutional and subjective axes in the pre-registration Project 2000 programme

Interviews with lecturers revealed the very concrete ways in which the university's organisational and physical characteristics impacted upon the individual's experience of engaging in delivering a coherent curriculum. It became apparent that each individual saw him- or herself

as having specific nursing and pedagogic expertise that was expressed in their own teaching load. The sense of specialist competence was played upon and modulated by:

- the fragmentation between the CFP and the branches
- the physical separation of sites reinforcing such distinctions through the territorial location of teaching groups
- the impact of modularisation in focusing and fragmenting each lecturer's relation to the whole curriculum.

To the non-nurse researchers who carried out these interviews, the commitment of these staff to their educational purpose was evident in the majority of cases. These were professionals engaged in producing the next generation of nurses, and their ego involvement in their own specialism was framed by this wider purpose. The interviews revealed how institutional constraints within the university setting tended to reinforce the specialist identity of lecturers and distance them from a full ownership of the whole Project 2000 curriculum. In the analysis below it is apparent that the negotiation of the inclusive identity of 'nurse' with the embedded 'specialist' identity found in the clinical setting is apparent also in the communities of practice in this educational setting.

6.3.2 Preparing the holistic nurse through the modularised curriculum

The university in the case study, like many British universities had modularised its curriculum. Driven by external pressures for quality assurance, and for a demonstrable equivalence of units of teaching and assessment that could provide the basis for an inter-university currency in learning credits, many degree programmes were repackaged into modules which were free-standing units of learning and assessment. These modular elements were also consistent with attempts in higher education to respond to growing student numbers and deteriorating staff:student ratios by innovation in pedagogic strategies. Thus in many universities and for many individual lecturers modularisation represented a twin challenge of a radical restructuring of the curriculum, accompanied by new pedagogic pressures and often additional assessment.

For respondents in the study, the overlaps of the transition to the Project 2000 curriculum with the merger into a university setting had provided a particular set of institutional pressures. As one lecturer said:

> *'But there is this other issue, what happened with the transition into Project 2000? Contextual issues affect everything don't they? We also went through two mergers, this one with the university being the last. You know, the curriculum we inherited had been written elsewhere and it's gone along the lines advised by the Board – of a thematic structure, so automatically it set up tensions. I mean I think I'm not that usual in the sense that I teach across three things. Most people teach on two. But the modules are so – I mean it's fair to say that they are, they have become, to some extent individual territory ... then my job in the class then, is to sell that, sorry, say "This is important. You've got to get onto this and chase up that". And I think perhaps all the lecturers are doing that; so the students then find it difficult to evaluate what attention to give to what. So there's a tension between that concept and the idea of holism, you know, per se.'*

This tension between the module as 'your individual territory' and its location in the wider process of nurse education is a specific site of the negotiation of individual identity and the institutional requirement to provide a coherent curriculum. Clearly for this group the structuring of teaching into modules had loosened their relation to the whole educational endeavour, whilst simultaneously providing a basis for sustaining self-identity. This fragmentation, however, had caused the break-up of the sense of working in a community of

practice. Under the strain of institutional reorganisation and the development of a new curriculum, 'thematic' groupings of lecturers that were intended to provide a forum for linking staff across branches and modules had fallen into disuse. Lecturers were increasingly encapsulated by their modular responsibilities, for which they were uniquely accountable; they occupied the majority of their time, and not surprisingly became central to individuals' professional identity:

> *'I think there is a certain amount of ownership: that's my module. I am responsible for it. I teach it. I evaluate it. You know some of them – It's a bit, you can say, its possessiveness.'*
>
> *'It lets you specialise and develop your own skills.'*
>
> *'Right so, I mostly, I teach all nursing theory and practice don't I.'*

Legitimate ego involvement in your own modules may, in a curriculum that is seen as heavily overloaded, produce an understandable egocentric view of the priority given other modules. Not only may it appear as demands for student commitment to 'your' module, as in the quote above, but it may also be expressed as a comparative marginalisation of a colleague's module. As one specialist teacher said:

> *'Well we have great difficulties, especially with some of our colleagues, because they don't see our specialism as being essential. So if you've got – sort of – individuals within the department who say "Oh that isn't as important as this"; that creates difficulties with us before we start.'*

In fact within the curriculum shared by this staff group there is an explicit expectation that all modules will feed off, and into, a core of Nursing Theory and Practice:

> *'The Nursing Theory and Practice is meant to draw on all the others and put it into a sort of a practical element of nursing.'*

However, even this is not entirely without problems, for questions of the location of content within this core may lead to 'specialist' modules being seen as the legitimate sites for particular inputs. In such discussions there is perhaps a concern with 'overloading' the core, and a sense that if a specific module exists why should you duplicate 'their' agenda, as for example in the following instance:

> *'... in my opinion the core skills of nursing are across the board; it doesn't matter whether you're working in community or ... But the very basic core skills – and what they are they? And then when we brain stormed what they were I mean one of the things I said was communication is a core skill of nursing – "Oh no! – That's got to go in the communications module" – and I think that's a big weakness of the new curriculum.'*

For this institution, and certainly for this group, modularisation is one of the most salient institutional features which impacts upon lecturers' self-definition and their relation to the whole programme. This was stated most bluntly by one lecturer:

> *'I think the modular system obviously has fragmented the course; and you only do your bit of teaching and then you move on.'*

But if modularisation has impacted upon lecturers' relation to their teaching it has also had a dramatic impact upon their relationships with their students. The curricular changes inherent in the introduction of modularisation isolated lecturers not only in relation to their modules but also to a distinct time frame within the curriculum. As their modules stand fixed in a specific site within the unfolding curriculum, student cohorts flow through it and pass on. This means further fragmentation of the community of practice – lecturers not only feel separated from one another, they are also dramatically separated from their students, with whom each now has limited contact:

'The biggest difference for me was that I used to have groups of students, we all did. Had tutor groups. So that I would meet the students on Day 1 and we'd be together for three years. And now, of course, that's got lots of space for tyranny as well hasn't it? You know, all sorts of concerns. But what I notice is the amount of the degree to which I no longer have the sort of conversation with the students that I used to formerly. And so, the term 'my students' doesn't come across my lips very often these days.'

The replacement of tutor groups with a personal tutor role has radically changed the relationship of staff to each student cohort. One element in this has been the sheer increase in student numbers, which itself jeopardised the previous staff-student relationship. As one respondent, in comparing the old and current regime noted, they now had an intake of almost 150 students on more than one site:

'And I think it was better addressed in those days because we took six intakes a year of 15 students; so you taught them from Day 1 to the last day and you were their tutor, you got to know those students and you dealt with loads of problems, whether they were personal or practice problems that they mentioned. Whereas these days I don't think it is addressed on a rational basis. So for instance: I tend to be the counsellor for the death and dying session and for the child abuse one and the number of people that I refer to outside agencies for counselling as a result of things that come out this is quite frightening.'

'I think it's because you don't get to know your personal students. I've got 10 students at [site A] but my office is here. I've got 10 students here so I'll probably know them better and also I've taught them.'

This lecturer is noting that increased student numbers and the restructuring of the tutorial function has limited their depth of knowledge about each student. Not only do they not know all the students in the cohort well, but they feel that they have diminished contact with, and knowledge of, their own tutees. As another lecturer observed:

'I'll be academic supervisor for, at the moment it's five in each intake ... but that's very tenuous you know. I'll see them about their sickness and absence, and I will see them and ask how they are getting on in branch, but it's not the same. So I feel that we have lost that with this type of course.'

Yet another member of staff, in expressing concern at the loss of continuity with students' professional development over the whole programme, related this quite explicitly to the rigidities they saw as built into the modular structure:

'Yes and I think we have lost that because of the module; the pressure for modularisation and being very ... very defined modules; they seem to be very rigid now within the university system. You have got to ... to do a module; have an assignment or some sort of assessment at the end of it and then it is closed. It's almost like that little package that you tie up, and I don't feel it should be.'

This situation had a real impact on individual lecturers' ability to feel fully able to engage with the unique person who must be nurtured and guided to learn how to use themselves, and to cope as individuals, in becoming nurses. There was a sense from some that it is no longer easy, or perhaps even legitimate, to engage intimately with such issues with students you know less well. Indeed one lecturer reported:

'Now we are even being discouraged from talking to them about anything personal because there is a counselling service in the university.'

Perhaps this is another instance where the institutional compartmentalisation of specialist knowledge, in this case counselling, is further fragmenting the staff-student relationship: a relationship already based on a more fragile temporal basis than was previously the case. While it is not possible on the basis of this study to 'measure' the impact of these institutional forces and the practices developed in response to them, it is hard not to anticipate that in their professional development the changed relationship with lecturers leaves much of students' personal growth less consistently monitored, and less adequately supported. In nurturing the emergence of the holistic nurse the national shift within universities toward self-directed learning may also, unintentionally, impact upon the student nurse's integration of self with practice. This may be a process that is increasingly dependent upon peers in the university and clinical staff in the practice placements. However, what seems to be lost in a number of cases is the ability of lecturers to assess their students' progress as peripheral participants in the community of nursing practice and the formation of their professional identity as a nurse.

Certainly for some lecturers this personal engagement with students was valued and important, in that they perceived their role as facilitating the personal growth of the nurse and his or her identity, rather than merely overseeing the efficient inculcation of knowledge. Whilst based in their modular specialisms, a concern with contributing to the development of the generic nurse, irrespective of branch, continued to inform their activity. Successful feedback of good results from module assessment was no substitute for seeing, and contributing to, the development of a competent nurse. The structure operating in this institution was seen by some respondents as depriving them of contact with this developmental process:

> *'I have two modules then, apart from my personal tutor role, five of them, I don't know what happens to them for the rest of the course you see ... but at the end of the day when they've finished the three year course, has it met the, you know, my expectation, whatever? Have they grown as a person, have they changed from the moment I saw them? I mean I have no idea. Quite a loss that.'*

6.4 The university-clinical placement relationship

At the heart of nurse education lies the integration of the educational processes in the university setting and the practice-based existential learning in the clinical setting. Chapter 4 demonstrated how university and clinical settings can be seen as two distinct, if overlapping, communities of practice, and Chapter 5 reported some expressions of scepticism from practitioners in clinical settings regarding the preparedness of Project 2000 students for entry into practice. The lecturers interviewed in this case study were well aware of the centrality of the linkage between the two communities and of the need to send students into placements with some skills they could employ in negotiating entry into the clinical community of practice. As one said of the CFP:

> *'You're addressing students' knowledge because you're preparing them for first placements and we do a lot of that. So you're giving them basic knowledge of nursing; I mean they are very wide areas. And as I've said we do the skills now, things like bed making, hand washing, maintaining a safe environment: we do in theory and in practice. And temperature, blood pressure, urine analysis, very basic skills to go onto first clinical placement.'*

The university-based staff are placed in a potentially fraught role as their students go into placement. At one level they themselves are vicariously being judged through clinical practitioners' estimation of their students' abilities. At the same time they are preparing students for practice with a knowledge base and theoretical agendas, which may have shifted significantly from that experienced by the students' mentors and assessors. In an ideal world there is a seamless thread linking the conceptual language and professional knowledge taught in the

university and that encountered in the clinical setting. In this less than perfect world the link tutor role of the lecturers is central to pursuing this ideal; however, pressure to fulfil their many functions in the university and to liaise with clinical sites does not always facilitate this role. Staff turnover within the university and in placements can break lines of communication, and for some the sheer number of link tutor roles impedes their effective fulfilment of the task. One respondent stated that:

> *'I'm the only experienced person left in pre-reg now [in this branch], which means I also link with every area where we send students as well as five wards because of my commitment ... I mean, I'm just not up to date with it because I haven't got the time. I read what I get sent but I don't meet managers any more; they know my phone number and my name and that's about it now, which is terribly sad because we're missing out so much.'*

Another described the link role as: *'mostly line of communication work'* whilst noting that *'some teachers in adult branch actually spend [time] and have hands-on experience'*. This awkward relationship between being the 'teacher' and having ambiguously legitimate practice credentials runs like a fault line beneath the relationship between lecturers and practitioners in the clinical settings. Clearly, continuity of personnel in building up stable relationships between *individual* partners in educating their common students is highly desirable. Indeed one branch lecturer reported that:

> *'We've got very good links with our practice areas. I've been visiting the same clinical areas for five or six years and I've got nothing but praise for the staff.'*

Regrettably the comments of other lecturers show this is not uniformly the case, nor is it reciprocal; one respondent noted the potential of clinical staff to undermine the efforts of university lecturers to prepare students for practice:

> *'But I mean it's staff on the wards as well that sort of ... Are saying to the students, "Well, what do you need that for?" So in a sense they'll think "Oh well" they say "What do I need that for?" So all the work that we're trying to do to promote them to meet – sort of psychological needs is being shut down.'*

However, this same lecturer later showed empathic understanding of the institutional constraints that may impact upon the quality of learning experience available in a practice area:

> *'Any clinical placement goes through, you know, transition. And how the staff are there will vary over time. So for instance, there is friction for other reasons, not usually to do with patients to be honest ... perhaps there's been reorganisation, staff changes, resource constraints, issues like that. Too many nurses working the bank, people are knackered – then what can happen, worst-case scenario is you get a very fragmented staff team. The students pick that up straightaway. But they certainly notice the consequences: i.e. they don't have those close relationships with clinical staff. There's not as much open discussion about what's going on, what's valued, what's right, what's wrong; whinges are not aired properly. And I think that sort of infrastructure impacts directly on what students learn.'*

Thus, a range of resource issues in both sites impact significantly upon those seeking to establish a coherent linkage between the educational process in the university and the learning environment in the practice placement. It is apparent that the experience of individual link tutors varies considerably; where this function appears to be seriously flawed it seems that issues of time and resources are the determining factors, rather than the absence of a wish to make this fusion work. In this school, in a way that is reminiscent of earlier findings regarding the university

placement relationship (Gerrish et al., 1996), the absence of a break-down of this relationship, rather than evidence of its seamless operation, seems to be the *de facto* measure of adequacy. If the whole staff group insisted on being facilitated through their workloads to be as efficient as colleagues who report positively on their relationship with placements, it would place painful demands upon programme management and, ultimately, real financial costs to the funding of nurse education. However, the centrality of the link tutor, as the accountable individual who liaises between the university and health care providers, developing and monitoring learning contracts and developing learning outcomes, is underlined by the UKCC (1999) *Fitness for Practice* recommendations. Additionally, that document and *Making a Difference* (DoH, 1999) argue for the importance of nurse educators in the university setting sustaining contemporary clinical expertise. This would enhance the legitimacy of their role in bridging the two distinct nursing communities.

However, on the basis of the data in this study it seems that given the current system of link tutors it is probable that two forms of exclusion are being set in place within the university-clinical setting relationship. One is the exclusion of lecturers from the community of practice at the placement site. Not only may their lack of familiarity with and competence in the nursing skills relevant to that site be an issue but, given their limited presence, they are effectively 'strangers' (Bauman, 1993) to the clinical staff. They are not totally strange and alien, but are only ambiguously 'one of us'. Given this status their joint supervisory role for students on placement must be negotiated with some delicacy; as the following example illustrated:

> *'But in psychiatry it's really difficult because, I'm sure you'll back me up on that [to a colleague], that it's difficult to get into where there is already an established rapport. A third person coming in obviously will ... [colleague cuts in with an example of their own embarrassing marginality on a visit to a clinical setting] ... [Speaker returns with] That's right, you're strangers.'*

Given that level of marginality, and the potential weakness of the link relationship, it is not surprising that colleagues such as this find themselves carrying out placement supervision one stage removed from the clinical setting, feeling shut out of that community of practice:

> *'I mean students can always explain or describe to us why they have done what they did more by discussion afterwards than being there on the spot.'*

A second and reciprocal form of exclusion that seems likely to follow from the observed pressures on the university-placement relationship occurs when clinical staff are not adequately briefed on the theoretical agendas being offered to students. However, if there is a problem in keeping mentors and assessors up to date with developments in the educational curriculum this is not uniquely the responsibility of the school of nursing. A focus group discussion with participants on ENB 998 programme revealed uniform and high levels of dissatisfaction with their opportunities to upgrade their knowledge base. Not only did they feel that their multiple clinical responsibilities had severely undermined their ability to provide adequate mentoring, they also felt starved of the opportunity to sustain their professional development. One extract from the transcript states this in the bluntest of terms:

> A: *'You know, we say like you're supposed to have a good knowledge base but how much time are you allowed out of your work to keep yourself knowledgeable. And you're just not part from the actual study day here, haven't been given any time off work to do any course work.'*
>
> Everyone: *'No, we haven't, no.'*
>
> B: *'It doesn't happen. It's non existent.'*

Clearly, institutional pressures within the clinical setting are exacerbating those forces operating within universities which inhibit the construction of a coherent learning environment across *both* sites; again this is not unique to this site (Gerrish et al., 1996). For the non-nurse

researchers on this project this *de facto* separation of educational staff in the university and clinical practitioners in the practice areas seemed unmistakably real and significant. This spatio-temporal separation of nurses – for all the university staff were qualified nurses – only serves to concretely affirm the distinct communities of practice operating on each site. And as seen in Chapter 5 regarding the clinical setting, and in this chapter, each site has distinct institutional forces shaping its reality. Located between these pressures is the domain of continual dialogue between teaching and clinical staff educating the same students: each group is sufficiently stressed servicing the immediate demands of their own site, and the quality of this dialogue is easily undermined.

Whilst there are examples of a successful mutual liaison that transcends these difficult circumstances, there is no lack of others that reveal how tenuous is the linkage between students' two domains of learning. Effectively, only students dwell in both domains; they must negotiate their differing feelings about, and status in, each. In the university they are 'a unit of resource', the *raison d'être* of the institution, and – given the Student's Charter and the marketisation of higher education through student loans – potentially awkward and litigant consumers. And from the evidence of this study they are liked and valued by university staff. In the clinical setting, however, they are no longer 'apprentices' who are a flexible addition to the workforce; as bursuried students they must negotiate an ambiguous 'peripheral participation' (Lave and Wenger, 1991) in a patient-, not student-orientated setting. Yet although this is a particularly stressful setting, it is the one that gives meaning to their aspiration to be nurses – it is *their* real world.

It is students, therefore, who truly are the vehicles through which theory and practice are integrated. They know both sites, and preponderantly represent each site to the other. Given the forces described above and their impact on the university-clinical area relationship it is not surprising that they should encounter some difficulties. As one lecturer described it:

> *'It's very difficult to talk about the theory and not the practice. And it doesn't make sense to the students if we just give them the theory and then a few months later they get the practice. They've got all these grand theories that they can practise in try-outs, but they can't with the client. So they're getting all these theories that they haven't got a clue, they've got nowhere to hang it. You know, there's nobody sort of out there working with them, showing them or for them to observe. And when you say to staff "Oh, what model do you use?", they say "Oh, well, a bit of this, a bit of that, a bit of the other". So the students are finding it quite difficult to link the theory to practice.'*

A shared commitment to nursing values and a wish to construct a positive and appropriate learning environment for student nurses is evident in both the clinical and educational settings. The evidence here regrettably suggests that there is a gap between this aspiration and the reality, in which the settings continue to operate as divided communities of practice with the students falling somewhere between the two. This is not, as stated before, the gap between theory and practice, but rather the need to create better links between two communities of practice.

6.5 The 'specialist identity' in the post-registration educational setting

As already demonstrated, the personal location of academic specialists within the modularised curriculum has reinforced the distinctive sense of personal specialist competence within lecturers. However, echoing the insights from the clinical setting, it is apparent that these institutional pressures can only have their effects through their action upon pre-existing subjective professional identities. This chapter has already discussed how 'ownership' of one's own modules has become a significant element in the pedagogic culture of this school of

nursing. It would, however, be misleading to see this as merely an expression of professional competition and territorial defensiveness. Certainly there may be institutional benefits to be had from defending such specialist identities, not least the ability to 'legitimately resist' claims on your time to teach elsewhere in the curriculum, or the construction of a sense of limited liability for a curriculum taught within a system under strain. However, the commitment and motivation already recorded as widely apparent amongst pre- and post-registration staff is founded on their subjective identification with their specialism. In the educational setting, as in the clinical setting, a consciousness of kind as a specialist within the generic community of nurses is powerfully present.

Thus, for example, one lecturer in speaking about her commitment to supporting pre-registration students explained it as an expression of her specialist identity:

> *'I think I'm a soft touch sometimes. And I think that's my health visiting background. You know I can almost feel myself going into health visiting mode; and the others tease me about it.'*

A post-registration programme lecturer, having defined orthopaedic nursing as her specialism, continued throughout the interview to indicate her identification with this identity in a manner that consistently indicated her powerful ego-involvement with those who share this specialism. There is a biographical trajectory of professional training which formally 'credentialises' this claim to membership with fellow specialists, and a strong subjective consciousness of kind. Something of this is revealed in this passage:

> *'I suppose for me, it goes back to "what is an orthopaedic nurse?" Because they know about the skeleton, and the normal skeleton, when you're actually making people comfortable you know how to put pillows and support them and so, to me, the actual practical skills of an orthopaedic nurse are actually much better than the practical skills of most other nurses; because they know the skeleton, they know what's the normal posture and normal positioning. But I'm a bit biased you see, because I'm an orthopaedic nurse. It's true though! Patients used to say to me, "Why, why do I sleep better when you're on duty? Why am I more comfortable? And the only reason was because I was an orthopaedic nurse.'*

This degree of pleasure and fulfilment in expressing a shared ownership in specialist knowledge and skills was not hard to detect within interviews with the majority of lecturers. There is an ontological validity to it as each lecturer has within their professional training made choices that have redefined their assumed competencies and identity within nursing. Thus in this school of nursing the transition of students from CFP to branch is clearly a professionally significant one, but also one full of personal relevance. As two pre-registration lecturers indicated, students very early in their education are engaged in a process of anticipatory socialisation, living through the CFP with their priorities already shaped by their future branch identities. Speaking of this process one lecturer observed:

> *'... that comes over I think because I have them as soon as they come to the branch and they always say: "Thank God we are in the branch because that's what we really came into nursing for, to focus on mental health".'*

Another, speaking of Project 2000 students, reported that:

> *'... they say, you know, "We couldn't really understand the Common Foundation Programme. We didn't really have any concept of why it was useful for us and we nearly left. But we were glad that we didn't because we were relieved when we got into the branch".'*

If branch identities within pre-registration education provide an institutional means of forming the basis for specialist identities then it seems that post-registration programmes are

a further means whereby formal education may confirm existing identity claims or allow for a transition into new identities. Interviews with post-registration programme lecturers and nurses on such programmes provided a valuable insight into the importance of post-registration education in nurturing collective identities and consolidating specialist nursing skills. Nurses entering into these programmes already have acquired the existential experience of working in specific communities of practice such as those discussed in Chapter 5. For such nurses some post-registration programmes are clearly an educational equivalent of their clinical practice in that they are explicitly designed to develop competence in specific nursing specialisms: for example, A&E, orthopaedics, burns or palliative care. Others, like counselling, offer advanced training in skills that have a wide relevance across a range of specialisms.

For nurses participating in the former type of post-registration programme there is an immediate and multi-layered synergy between the community of practice of their clinical setting and the emergent community of practice of their programme. They bring with them comparable experiences of the distinctive institutional environment that constitutes their working environment. They are likely to have shared values and strategies that shape their ability to operate in that environment. And, importantly, they have a strong consciousness of kind that facilitates their entry into a shared educational experience.

A strong example of this phenomenon was evident in relation to burns nurses who, like A&E, hospice and other nursing specialisms, share very particular working environments. As a post-registration lecturer indicated, this community of practice generates a strong workplace culture and identity:

> *'Because burns units tend to operate as insular units, the nurses tend to go out a lot together … quite a close-knit unit; and I think they get a lot of support from each other.'*

And speaking of the distressing condition of many of their patients and how they collectively negotiate this:

> *'What seems to be quite devastating to an outsider, they tend to take for granted. They don't, but it certainly would appear that way if you walked in.'*

This awareness of a shared commitment to an area of practice regarded as particularly stressful is perhaps reinforced by the dual processes of self-selection to work in this area, and the knowledge that those who 'cannot handle it' drop out. This *ésprit* was certainly evident in the group discussion with the members of a current programme, and as discussed in Chapter 5 they, like some other specialisms, saw the unique challenges of their area of work as enabling them to deliver high quality nursing care.

An institutional feature of post-registration education which is supportive of the development of strong group cohesion is the size of the membership of such programmes: for example 12 students on one in neurological nursing and six on another for burns nurses. Certainly from the perspective of the lecturers it is usual for such groups to form strong bonds:

> *'As a group they get on very well – usually. Sometimes you get an odd one who can cause a bit of disruption, but generally yes. And they all socialise together while they're on the course; and they tend to keep in contact and become friends.'*

The trust and sharing that can be developed within small groups who share a strong professional identity is clearly valued by lecturers and participants not only because of the personally gratifying level of social cohesion, but also because it facilitates learning. As an A&E post-registration lecturer observed of one module:

> *'… so the A&E group do their own – we've had luxury teaching for ideas in small groups; very privileged. And it's in that module that an awful lot … comes out.'*

A strong statement about the pedagogic benefits of small cohorts came from a lecturer on another post-registration programme where a formal maximum limit of 20 students had been set, but the aim was to restrict intake to 10-15. For this lecturer interaction among all the participants and an ability to address personal experiences and feelings are central to the shared learning:

> *'I am not teaching monkeys to perform tricks: I'm looking at how they relate to their clients – what it means to them.'*

From the interviews with lecturers and students it became evident that entry to a post-registration programme is motivated by a range of, not mutually exclusive, rationales. It is in the interest of nursing managers to ensure that in terms of staff morale they facilitate professional development among their workforce, and with the consolidation of clinical governance within health care it is essential that they sustain the appropriate skill mix. Certainly this managerial interest was evident in the interviews. As one specialist lecturer observed:

> *'I think all general hospitals have dedicated orthopaedic and trauma wards and so managers like nurses working in those areas to be qualified in the specialism within which they're working.'*

This managerial initiative may be a valued catalyst to nurses choosing to seek post-registration education. One participant on a post-registration programme indicated the potential significance of this managerial function with the following statement:

> *'Well the manager, he puts out the seeds a bit doesn't he obviously: and then, so I thought – oh yes that's a good idea.'*

However, if managers may be valuable in facilitating staff choosing to take up the opportunity of post-qualifying education, the interviews are equally rich in examples of managers being unable to protect nurses' time, either to allow them onto programmes, or, even more distressingly, to guarantee their continued participation in such programmes. The shortage of nurses and the heavy demand for nursing care are evident institutional pressures having a deleterious impact upon the take-up of post-registration programmes.

There are, of course, many more personal reasons why nurses may choose to follow post-registration programmes. One pragmatic motivation is the relevance of such qualifications to personal promotion within the nursing profession. As two nurses commented:

> *'It's like, one of the courses you've got to have to get anywhere.'*

> *'To get any higher than an E grade you've got to have it, more or less. So, you haven't really got much choice.'*

However, promotion, a willingness to accept further responsibilities and a desire to enhance their nursing skills are not mutually exclusive options for a nurse. Indeed, it is reasonable to assume that they are routinely intermingled. Certainly these interviews did not suggest that there is a perception within the nursing profession that the benefits of post-registration education for personal promotion makes their acquisition suspect or morally reprehensible.

If there is any indication of immediate self-interest amongst nurses entering post-registration education it is that for some it offers a form of respite from the stresses and loss of morale that may have accumulated in their workplace. Both lecturers and course participants recognised this motivation as a real and justifiable reason for enrolling on post-registration programmes. Recognition of this as one potentially powerful feature of post-registration education is essential to lecturers' ability to factor exhaustion and demoralisation into the determination of their pedagogic rationale. Although they may have only limited current clinical experience, they do nonetheless demonstrate an explicit awareness of the stresses operating within the institutional context of their specialism's community of practice. Thus one lecturer, having discussed the stressful world of clinical practice in their areas of specialism reported that:

'In terms of post-registration students who come on our courses, they are well socialised into the real world. And going under rapidly a lot of them aren't they. It's central to every discussion that we have.'

And in blunter terms a course leader on another post-registration programme commented that its core aim was to develop positive attitudes since:

'There's a lot of, I feel, a lot of negativity around in nursing today. Some people come on the course demoralised, they're ready for a break.'

If, as has been argued above, there is a flawed pattern of routine communication between nursing staff in the educational and clinical settings, these interviews reveal a strong general awareness of the conditions of practice prevalent in clinical settings among the lecturers. Time and again they indicated an awareness of the constraints arising from the limited resources determining the delivery of nursing care. There was also a complementary concern about the long-term effects of conditions on routine practice – not only in terms of demoralisation and potential burn-out, but also in relation to a concern with how clinical staff adapt to these circumstances. Of particular concern were maladaptive strategies to cope with the emotional costs of nursing and with a loss of critical reflexivity in practice: what one lecturer called 'ossified practice'.

This sensitivity to the current context and experience of clinical practice fed strongly into lecturers' aspirations for the learning outcomes from their programmes, and into their 'qualified' expectations of students' ability to implement in practice their new learning and skills. As one lecturer put it:

'They go back to practice and they're longing to put everything they've learned into practice. But unfortunately you've got to have, and I'm not blaming management, but you have to have an effective management structure to allow that to happen.'

And another lecturer echoed this concern in suggesting that while changes in some individual skills may be sustainable, others will require a structural response within the clinical setting:

'I think it's the opportunities that are not there in the clinical areas for them to develop and take it forward. But I do think their knowledge and their understanding and their reflection stays with them. But it's how they actually implement that might be where they come unstuck.'

Not surprisingly, given the above comment, one of the dominant aspirations of post-registration lecturers was to develop their students' professional confidence. If 'knowledge is power' it is evident that one benefit of specialist nursing identities is the opportunity to acquire arcane 'specialist' knowledge. As one programme manager made explicit, this specialist knowledge operates not only to confirm in-group identities, but also to provide legitimacy for challenging the authority claims of other professionals. Nurses may become invisible as part of the physical context of the 'nursing environment' through which other professionals move. And as described by this educator these professionals assume 'a presence' specialist nurses may challenge:

'Other people who come in have this, it's right, they have this presence and it's a very subtle thing. But once you've actually realised that you're not insignificant, and the way to learn that is to be a specialist in your own field, then you have got the same presence as they have.'

Given the concern already expressed in this report about the extent to which institutional forces may deskill and disempower clinical staff, it is hardly surprising that confidence-building is one of the ambitions of post-registration programmes. Where competence is present but suppressed through institutional forces, confidence is a valuable, clinically relevant

attribute, in releasing skills for performance. As another lecturer spoke of their intention to promote confidence among students:

> *'Confidence in their ability to function as a member of the team, confidence to assert themselves where necessary and confidence that what they're doing is right.'*

The relevance, indeed the clinical necessity, of such confidence is the context of different post-registration programmes as critically important to creating the appropriate degree of professional assertiveness in relation to trusting your own skills, in speaking for the interests of the client, and – melding both of these – assertiveness in interprofessional settings, ensuring that the nurse's perspective and expertise is heard and valued. The ability of post-registration programmes to achieve such an outcome may partially be a consequence of the forethought and skill of those who construct and deliver them. However, it seems equally probable that the strong sense of consciousness of kind, and the attendant strong culture of mutual support and sharing that characterises these programmes is also a critical factor. Nor is this temporarily confined to the duration of the programme, as lecturers and students all affirm the importance of the enduring relationships developed. As one lecturer put it:

> *'There's eight departments come here to do this course, and they stay friends and they form a supportive network.'*

Post-registration education occupies a distinctive location within the educational setting of nurse education. In the majority of instances, educational staff and students share an already well-formed collective specialist identity. This is particularly so since a formal pre-requisite for attending these specialist programmes is six months of relevant practice, and it is more usual for students to have worked within the specialism for a number of years. On the basis of this shared professional experience and collective identity there is a particularly strong group psychology at work. Professional and personal development in this environment can be advanced simultaneously, and with some safety. The typically small numbers on the programme, and the strong sense of 'shared fate', facilitates a strong supportive in-group culture. This itself aids both the acquisition of new knowledge and a collective 'reaffirmation of the faith'; a shared revitalising of commitment to their specialism. The sustainability of this new knowledge and confidence is, however, highly dependent upon the presence of propitious supporting factors being available upon the students' return to their clinical settings. New-found 'specialist' networks may be one positive resource but institutional resources will remain critical.

6.6 Conclusion

This, and the preceding chapter have shown how the concepts developed in Chapter 4 have relevance for the world of nurse education and practice. Communities of practice have been revealed as uniquely constructed through the intersection of institutional and subjective forces operating in each location. Nurses are seen as actively negotiating the formal definition and personal meaning of their work in the face of what is often seen as impropitious, or even hostile, circumstances. This struggle to defend the core identity of 'nurse' and the embedded identity of 'specialist nurse' was strongly present in both the clinical and educational settings. A subjective commitment to an ideal of the caring nurse, delivering high quality holistic individualised care, emerges as the rather resilient rock against which the waves of institutional and managerial change have broken. The cost to individual nurses in seeking to sustain this commitment will already be apparent; one aspect of is examined in Chapter 7, as the processes of coping are revealed.

Traynor's (1999) valuable text *Managerialism and Nursing*, drawing upon a very different database, provides valuable complementary support for the argument developed here. His extensive survey data valuably complement the case study-based data in this report. In a discourse analysis deconstruction of 886 spontaneous written comments on a large RCN questionnaire study, Traynor offers valuable insights into how nurses construct a discourse that

positions them in relation to the current institutional context of their work. His findings resonate strongly with those presented above.

From Traynor's account there emerges a picture of nurses struggling against the managerialism and resource-starved pragmatics that shape contemporary nursing practice. He argues that:

> *'Perhaps it is consistent with the subjectivities performed by managers and nurses that the former should adopt the language of solidarity with their organisation, of control, of the rationality of the statement based on scepticism or observation and that the latter, lacking this organisational identification and not using this vocabulary, had learnt to draw upon a moral discourse to characterise their subjectivity.'* (Traynor, 1999: 141)

Central to this moral agenda was the concept of caring, which was itself seen as being defined by a personal commitment to the patient, and by a practice shaped by the personal agency of the nurse rather than a formulaic delivery of pre-established nursing competencies. This moral agenda was further sustained by the means through which nurses resolved the misfit between their commitment to caring for patients and the inadequate resources to facilitate this. Faced with this dilemma Traynor argues that nurses are prone to invoke a discourse of self-sacrifice – an assertion that they operate above and beyond a mere institutional job description.

Traynor's account of how nurses construct their identity within the institutional context of health care delivery is consistent with, and complements, the analysis presented here. It is something of an irony that nursing within the current NHS could not be sustained without this strong consciousness of kind and the continued commitment to caring, and that much of the burn-out and flight from nursing is also a consequence of individual nurses' inability to successfully continue to negotiate the mismatch between this ideal and the realities of practice. This and the preceding chapter have shown how much of the experience of clinical practice and nurse education is characterised by fragmentation: fragmentation of attempts to deliver care to the individual client, fragmentation of the educational process and fragmentation of the educational and clinical communities of practice. These chapters have revealed a good deal of the forces that generate this fragmentation, and of the bases of the mechanisms that seek to challenge and contain it.

7.1 Introduction

Chapters 5 and 6 showed how in nursing stress and emotion are dealt with through strategies that are collectively owned within the community of practice. That community, one's support network, may stretch beyond the working environment, as with those who extended their community of practice by developing networks from post-registration programmes. For most nurses, though, the important relationships that sustain them through the stress and emotion in their work are found in the communities of practice in their place of work. The community of practice in most nursing contexts is bound together by emotion. Humour is one of the key emotions used to bind relationships within the community of practice and to deal with embarrassing or difficult situations. But humour is one element in a more powerful sense of belonging that develops within a community, a consciousness of kind which is a shared sense of identity and a collective ownership of the job's stresses and strains.

In contemporary nursing practice most of the stress is due to an awareness of the precariousness of care delivery in a health service with both constantly increasing demand and constant pressure to make the most of limited resources. In the face of this, most nurses still attempt to live up to the aspiration of being a 'good nurse'. This is an existential commitment to maintaining the authentic identity of being a nurse and to sustaining the core nursing value of holistic care, yet having to accommodate this to the structural constraints of the workplace. This struggle often leaves nurses individually vulnerable and open to exploitation and burnout. It also means that workplace responses to this sense of fragile identity are negotiated as interpersonal strategies that have been normalised within the community of practice.

Some research suggests that 'stress' is part of a stress discourse that has arisen as a response to modern organisations (Newton, 1995). Employees are expected to be 'stress-fit' and to deal with every situation without becoming over-emotional. This has led to the 'stress industry' involving counsellors and self-help gurus, and to a culture employing concepts such as workloads, burnout and strategies for coping. However, while Newton seeks to both problematise and historicise the concept of stress, he does not deny that certain modern organisations place undue demands on their workforce. He does make the point, though, that within the stress discourse it is rare for sources of stress to be identified as belonging to the organisation of the workplace, management practices or the use of resources. Instead, the discourse is highly individualistic, concentrating on individuals and their coping mechanisms. While this may be true for other jobs and professions, this is not entirely the case in nursing, because nurses work within stronger and more clearly-defined communities of practice and while there is evidence in this chapter of the use of individual coping strategies, collective strategies are much more evident. This is to the point where the stress discourse is often denied by nurses, especially in the data from A&E where one would expect the concept of stress to be easily recognised. Instead, nurses in A&E tended to regard the pressure of their work as part of its excitement and challenge. So recognition and use of the stress discourse is variable and, like all other aspects of nursing, highly dependent on the particular context of the community of practice.

Having said this, many nurses recognised and understood aspects of their work in terms of stress, and in all contexts of practice observed there appeared to be three main sources of stress. These include the institutional sources involving the management of resources. While nursing can be seen as an imagined community of practice, involving core values such as holistic care, these values must often be put into practice in overstretched and understaffed wards. Not only is this a source of stress in itself in terms of a nurses' workload, so is the knowledge that the nurse may be unable to deliver the quality of care she would like to. Second, into this context

there are also pressures from patients, families and other professionals. While the core values of nursing that mark out the imagined community of practice emphasise caring for patients and families, as well as the value of interdisciplinary co-operation, the reality of the everyday community of practice may not allow for this. The values of caring and meeting patients' needs mean that nurses are expected to adopt a generally sympathetic or empathic approach; if this is threatened by institutional pressure then the fragility of care becomes palpably real. There is the danger that anger or irritation may be expressed, shattering the values and identity of the professional nurse. This leads to the third source of stress: emotion work and the management of emotional labour. When the performance of the caring nurse is threatened and the fragility of care becomes real, the nurse is more conscious of having to stage-manage an emotional performance: to put on the face of the care-giver and suppress negative feelings. Even when the researchers found nurses who were prepared to express negative emotions, there was much concern about the appropriate time, place and manner of such a performance. Nurses may also feel the stress of having to perform particular emotions in distressing situations to reassure patients and control the flow of information. All this adds to the stress of nursing and invites the creation of coping strategies, particularly the containment of emotion within the overlapping dimensions of time, space and the body. However, coping strategies vary between contexts and specialisms as different pressures come to bear. This will be examined in the light of the three different sources of stress, which emerge in a variety of ways, beginning with the institutional.

7.2 Institutional stresses and the management of resources

A major source of stress for nurses stems from the organisation and management of health care services, involving the rationalisation of resources. This has resulted in recurrent 'bed crises' on hospital wards, where there appear to be insufficient resources to maintain a proper service. Under such conditions, nurses must manage as best they can, juggling patient need with the availability of beds. Much of this everyday management of resources falls upon the senior nursing staff. Furthermore, the rationalisation of resources has resulted in a shortage of qualified nurses, so that nurses are overstretched in terms of their ability to keep up with patients' needs and demands.

Pressurised working conditions were observed in virtually all the workplaces studied, but were manifested in different ways. On the elderly psychiatric ward there were examples of how multiple stresses repeatedly experienced can lead to chronic burnout. Nurses reported how morale was low due to the busy ward, increased physical aggression from patients and a lack of male staff. This ward received three admissions during one shift, two of which were males sectioned under the Mental Health Act. On this particular day, staff numbers were low and included only one first-level registered nurse, the only male member of staff. In order to boost male numbers and keep the sectioned patients under observation, a male health care assistant was taken off a care and responsibility programme, designed for the management of violence and aggression. Meanwhile the male nurse attempted to co-ordinate the running of the ward while intervening to stop two male patients absconding. He compared trying to fulfil multiple functions to being at busy airport:

> *'You've got other things to do at the same time, I mean, I was having calls from other wards ... If you're the only qualified nurse ... there are other things ... you've got to do yourself. So you're getting demands and you're putting people off or I tell them "I'll get to you when I can," and you finish up like [an] airport, you know with a stacking system ... So they're there in the back of your mind and you've got all that catching up to do then later.'*

Here is a stark illustration of the contradictions between caring and the demands of institutional pressures, such as lack of resources. There is a palpable sense of the fragility of care delivery in the quotation. In this instance, the male nurse coped with these stresses by blocking

communications with patients. For example, he would place a physical barrier (a desk, drugs trolley or bed) between himself and the patient, or focus on another task while a patient was talking to him, thus avoiding eye contact. Physical activities were therefore used to distance himself from the patient as well as to signal the limitations of the relationship.

Despite this, the nurse denied feeling stressed, claiming that 'I can do this job with my eyes shut'. This gave the impression that he relished the pressures and proudly articulated his ability to deal with them, despite sacrificing his caring role. He was attempting to keep emotional control despite external and internal stresses, thereby maintaining the performance of 'a good coper' (Newton, 1995).

Each community of practice observed had its own unique pressures and nurses created their own collective and individual strategies for coping. In community psychiatric nursing the main tension was in terms of caseloads, which the community psychiatric nurses (CPNs) felt unable to manage properly because they were having to take more cases from social workers. Here, the pressures were formed because of interprofessional relations within the multidisciplinary team. The CPNs also expressed concern over a lack of managerial support for limiting their caseloads. In this situation they perceived themselves to be vulnerable and lacking in support and, thus, open to inordinate pressures.

In contrast, on the surgical ward a bed shortage created a crisis for nurses. Because of an excess number of patients with acute illnesses admitted in a short time, the medical wards were filled and the surgical ward had to admit the 'overflow.' Here nurses felt torn between coping with a lack of resources and the demands of patients and their significant others. Not only were the nurses having to try to find beds for patients, they were also constantly taking telephone calls from other wards wanting to transfer patients, and from relatives and friends enquiring about patients on the ward. Among these organisational stresses, nurses must also find time to care for patients.

7.3 Power relations and containment: stress from patient, family and professionals

A second source of stress emerges from the needs and demands of patients and their significant others, from which nurses cannot easily escape. As nurses are the interface between patients and their significant others, on the one hand, and the health service on the other, they are constantly caught in the tension between the two. Doctors and other professionals can retreat to more private spaces, such as offices and consulting rooms, whereas the nurses' community of practice in the hospital is located in the patients' space – the wards. Lack of spaces for nurses in the hospital, private places they could go for 'time out' or to cry after a particularly distressing experience were often observed. Also, nurses are increasingly expected to deal with a range of other professionals in a multidisciplinary approach to health care, and power relations between professionals can add additional pressures to the management of nurses' time.

On the elderly psychiatric ward, long-standing, difficult power relations were observed between the consultants and nurses. The nurses described how consultants were not consistently communicating with them about their interventions so that patients and families often knew more about patient care than nurses, leaving them feeling peripheral and 'stupid.' Consequently, the nurses often felt undermined and unsupported by the consultants, yet at times masked their feelings in order to support the consultants in front of others, which in some instances led to taking the blame for consultants' errors.

Power relations were also reflected through gender differences, which became apparent when observing how nurses on the ward reacted to detained patients and to more generalised stresses. In one case, male nurses used their physical presence to stop a detained patient leaving, combined with authoritative instructions such as *'go back to the lounge, you cannot leave.'* In

another instance, threats were used, such as *'if you do that again, I'll take you to your room. Is that what you want? Then stop it.'* Such remarks illustrate the power relations between nurses and patients, which in these examples are reminiscent of the power relations between a parent and child. On this ward, then, there was a strong sense of the male staffs' anxiety to contain aggressive situations through physical means. For example, when exploring alternative ways of dealing with one incident a male staff nurse stated:

> Interviewee: *'I mean I could have taken him down onto the ward ... physically.'*
>
> Interviewer: *'Physically?'*
>
> Interviewee: *'Yes, oh yes, no difficulty. I could have taken ... I would have had to manhandle him down onto the ward, which is what, twenty metres away, or so. But at that time ... I'd arranged for someone else to come and I was prepared to wait it out, and be patient and that's what I did.'*

This focus on physical containment also included seclusion and chemical containment:

> *'I could have given him some medication ... and insisted on it, insisted on it because I did with somebody else, I did with another patient ... I would have secluded the pair of them, short term, but that wasn't an option [because there was no seclusion room].'*

By way of contrast, female nurses engaged patients in diversionary conversations and activities, which reduced the level of confrontation and aggression, helping to establish some form of therapeutic relationship. This was rationalised by a male nurse as patients responding better to females than males; it was not the skill or approach that was successful, but the gender of the nurse.

Here, stereotypical gender roles were reinforced in dealing with aggressive incidents. Male staff used their physical presence and drugs as a barrier to stop patients, limiting the level of engagement on a human/emotional level, while female staff used a soft voice, touch, eye contact and humour to greater effect. This was explored with one male nurse who, whilst accepting that the approach taken by the female nurses may have been more appropriate, exhibited his anxieties to protect female staff and contain the situation:

> *'A female nurse might have been better with him, however, you can't risk it at that time, him swinging out at a female nurse ... you can't risk a female being assaulted. Not when there's two male nurses on the ward ... It's not unreasonable for a female nurse [to be] frightened of being injured.'*

As well as reflecting gender differences, Handy (1990; 1991) suggests this form of stress is continually supported by the institutional contradictions intrinsic within psychiatry i.e. control and care, support and policing, institutionalising patients and encouraging independence. However, it also illustrates the fragility of care under institutional pressures and how power relations come into play in such situations between different ranks and genders. Female nurses seemed able to maintain the caring role more easily than male nurses, who quickly fell into the masculine strategies of physical containment and threat. However, in all cases stress levels were high as the nurses sought to maintain both care and control under great pressure.

Another patient-related pressure was the frustration felt by the CPNs about their inability to solve seemingly intractable social problems, which they identified as the root of many patients' poor mental health. These problems were wide ranging – poor housing, low economic status, abuse from individuals within the neighbourhood and other forms of social exclusion. In some instances patients' relationships were also seen to be intractable. One CPN, who believed her patient's reactive depression could be lifted by a stable relationship, talked of her desire 'to wave a magic wand':

Interviewee: *'Yeah, you know I wish I had a cure. You know I think I mentioned in the car as we drove away from Ellie's but I've often thought "god, don't I know a single man who is lovely and ... they'd get on like a house on fire and that he'd take care of her and give her all these things?", certainly I mean I like her as a person and you know it would be wonderful, but that wouldn't happen would it? It's hard.'*

Interviewer: *'Does it make you feel impotent or ...?'*

Interviewee: *'... I don't propose to be all things to all people and I know realistically that I can't. It might be frustrating, um, I think it is frustrating when you go in and you do what has to be done what ever that is and there is little outcome that is any different to when you first went in. And that is frustrating, but at the same time you know realising that I have limits as well, that there are certain things that I cannot influence.'*

This CPN acknowledged that there are sometimes limitations to what she can do to improve an individual's situation. She can empower this patient to widen her social circles or improve her confidence and self-esteem to increase the opportunities of meeting a potential partner, but she cannot directly influence this area of her patient's life. Another CPN had a similar patient with a reactive depression due to marital problems. Despite numerous offers, this patient would not engage with marital counselling, accepting only medication or hospital admission. This CPN again felt a deep frustration, which was manifested in partially blaming the patient for 'failing' to act or take any responsibility for the situation. This is reflected in previous research with social workers, where chronic material deprivation led to feelings of impotence in the social workers and at times a culture of blaming the client when interventions failed to work (Satyamurti, 1981; in Newton, 1995). The inadequacy and frustration felt in such situations leads to conflict in the practitioner when the very people they wish to help are blamed for not wanting to be helped, often resulting in a withdrawal of emotional labour and perhaps eventually interventions *per se* ('We can do nothing for this individual, unless they want to be helped'). As in Satyamurti's research, the CPNs had different responses to situations over which they had little influence. The first CPN quoted above understood the contradictions, and accepted her limited ability to help in certain instances. This enabled her to continue to work with clients, without withdrawal of emotional labour. However the second CPN, while acknowledging her limitations, distanced herself from some clients, effectively throwing her hands up in the air as if to say 'What can I do, if they don't accept what I have to offer?'

7.4 Emotion work and its management

A third source of stress is the pressure upon nurses for a required style of emotional labour or emotion work. Over the last 20 years there has been a growing awareness that those who work in constant interaction with the public engage in a form of emotional labour (Hochschild, 1982; Freund, 1990; 1998). This involves ensuring that one always performs the 'correct' or acceptable emotions in dealing with people. In nursing, such emotional labour is especially valued as nurses are expected to engender in others feelings of being cared for. As McQueen (1997: 234) said, *'attempts are made [by nurses] to suppress inner negative feelings, for example, annoyance or disgust, while the expression of empathetic feelings is now being valued in caring relationships'.*

Furthermore, this form of emotion work is intensified in nursing, as nurses often deal with highly charged emotional scenarios involving patients and their significant others. Nurses are increasingly expected to be highly skilled in dealing with patients, and those close to them, in such circumstances. There were many instances in the observations and interviews where nurses were confronted with such demands, and few nurses can be unaware of the need to deal with the emotional and psychological aspects of illness as well as its physical manifestations. However, emotion work does not just involve the interaction between the nurse and the patient

and their significant others. As Olesen and Bone (1998: 321) point out in their study of nursing in the USA:

> *'In sum, nurses working in today's rapidly changing health care services face multiple demands in which sophisticated emotional skills and flexibility are needed to handle the increased workloads, high levels of patient acuity and labour speed-ups. Nurses manage their own feelings, those of their patients and those of other workers, each interaction grounded in the shifting contexts of cost containment. ... Paradoxically, managed care is simultaneously diminishing the structural support for nurses to provide traditional emotional support, and increasing the emphasis on customer relations and patient satisfaction as quality measures of successful outcomes.'*

In such a context of structural limitations, nurses develop different strategies to enable them to deal with the varying demands upon their emotional labour.

7.5 Containment of emotion: space, time and body

7.5.1 Bodily and spatial containment

One of the main coping strategies observed was the containment of emotion, a process that works both on the level of the community of practice and on the individual level. Within communities of practice, emotions are contained within time/space to particular times or locations. Emotion can also be contained at the individual level by nurses recognising the bodily sensations of a certain emotion, yet denying that they actually 'feel' it. Here, the emotion is contained in the space of the body, effecting a body-mind split within the person who acknowledges the somatic aspect of the emotion but not its psychological realisation. This splitting between body and mind is not proof of the Cartesian dualism criticised in Chapter 4. Human beings are not *inherently* divided between the mental and the emotional, but such a division can be *produced in certain contexts* as a coping strategy. It can also be produced where certain emotions are felt but must be denied, as in cases where nurses may know distressing news about a patient's condition yet be unable to tell them. In such instances, distress must be hidden in order to put on a calm and reassuring performance.

This was demonstrated by a nurse whose response to aggressive patients was to try to physically contain his emotions in the space of the body. While he reflected on his bodily sensations and the way he acts on them, he denied that he himself felt any anger 'mentally':

> *'I mean I can be, I can be, I can be ... physiologically if you like, angry. I mean I will get hot, and red and pushed, push people about an' so forth but mentally, I'll, as I said earlier, no, no.'*

The strategy of emotional detachment, of viewing aggression as just another aspect of the job with clear boundaries around it, has been identified elsewhere as a coping strategy where the individual focuses on the limits of the experience ('it's just a job, my shift ends soon') (Hochschild, 1983).

The containment and compartmentalisation of emotions was also evident in the community of practice within the A&E department, where nurses often had to leave one highly emotive piece of work (e.g. death of a child) to go onto a more mundane task (e.g. bandaging a cut finger). The nurses described this process with great clarity:

> *'What we often do is, after a very, very emotional thing, we give each other a hug and say "Come on lets get on with it". And you know we go off and start on whatever's going again. Because its very, very difficult sometimes when you've had a really traumatic case, very emotional – but then you have to snap out of it and straight back into a waiting room full of trivia. And you've just got to be able to do that.'*

This nurse described several strategies utilised that enabled him to cope with his emotions. He not only used the physical and emotional support of his colleagues within the community of practice (getting a hug) where this type of support seems to be built-in, he also switched between tasks in the spatial context – which also allowed him to change the bodily experience of emotion. For example, when nurses changed the focus of activity (from acute trauma to cut finger), they not only switched spatial context, but the body also learns to switch off the adrenaline flow associated with high arousal. The skill of quickly dealing with and closing off emotions, rather than being a defence mechanism, appeared a tactical strategy needed to survive working in the A&E environment:

> *'I think you have to realise that you have got to go forward, you've got other patients to treat and you can't obviously build it up and stack it up to replay that emotion over and over again. So you have got to deal with that emotion not necessarily there and then, but … within a reasonable length of time and then let it go and move forward. Because if you stacked every emotion up that you had in here you wouldn't be able to function.'*

Another technique the nurses unconsciously used to manage their emotions in emergency situations was to view the patient's body as a broken machine that needs fixing, thus turning it into an object; the 'body as thing' (Harre, 1986). However, reducing the patient to an object, something to be fixed, also performed a useful function in the management of emotions. The level of activity and role of technology served to distance the nurse from the experience of the patient, so the nurse did not have the time or space to empathise or embody that experience. This depersonalisation or disembodiment was a short-term coping strategy that enabled nurses to focus on the task in hand during high arousal situations. Nurses described how it was only after the patient had stabilised or, in some cases, died that they could physically and emotionally step back from the event and relate to the lived experience of the patient:

> *'I think it becomes a person, once we have done all the technical things and then we start doing all the niceties for the patient like cleaning them up, making them look respectable for relatives to come and view … this is where he starts being a person.'*

Note the absence of the personal pronoun at the beginning of this quotation; the patient is described as 'it' until the nurse talks about the personal, caring aspects of his work, when the patient becomes 'he'. This demonstrates the role technology plays in disembodying the patient, and the role basic care plays in embodying and reintegrating the identity of the patient for the nurse (Harre, 1986). For this nurse, basic care giving and attending to personal needs was just as important a part of his job as attempting to preserve life.

During emergency situations, each member of the trauma team has his role in fixing this broken machine. Included in this division of labour and of the body are the emotions, which are separated and dealt with by a different nurse in a different space:

> *'But you have to remember as well that we know while we are doing that there is someone dealing with the emotion with the relative. And that, you know for a fact that that's being dealt with and it's being dealt with well. So you are not thinking "Oh the poor mother what is she thinking now?" Somebody is dealing with that aspect of the trauma, so you can get on and do what needs to be done without having to think of the emotional things at the time.'*

This colonisation of the body and compartmentalisation of emotions can be described as 'tactical holism', to reflect the nurses' acceptance of the necessary shifting priorities. It is not really an example of dualism, but a way of coping with extreme situations that involves containment of feelings to certain places of the body. Elsewhere in the nursing literature, such

fragmentation of the body has been criticised (Lawler, 1997). However, it is difficult to envisage how extreme trauma could be managed otherwise.

7.5.2 Bodily performance, information and spatial context

Freund (1998) claims that space has to be a master metaphor in the study of emotions, as spatial contexts are important for sustaining performances, establishing boundaries and regulating the flow of information. Given that it is argued here that emotions are performative and involve communication through words, gestures, facial expressions, posture and other bodily symbols (see Chapter 4), they are central to managing the flow of information. A spontaneous look of distress or concern by a nurse may give the wrong message to a patient. Examples of this can be found in those cases where nurses have to deliver bad news to strangers without having any previous relationship with them. This necessitates a rapid invocation of empathy and a summoning up of emotional strength, as one nurse describes:

> *'I've got to psyche myself up before I open the door ... I just take a deep breath and think what am I going to face this time ... And you never know until you open that door what reaction you are going to get.'*

This action of taking a deep breath and physically engaging the body is evidence of the deep, embodied acting necessary to control demanding emotional performances. As Hochschild (1983: 220) says, *'when we manage an emotion, we are partly managing a bodily preparation for a consciously or unconsciously anticipated deed'*. For example, when delivering bad news, the nurse must prepare for an unknown audience and response. She may have to mask or display her own emotions while judging how to respond to the emotions of others. However, this is not a cynically stage-managed performance, rather it demonstrates the rapid, intuitive judgements needed in such situations (which are discussed at greater length in Chapter 8).

The concept of performance was discussed with one nurse from a surgical ward who claimed that the way she approached her profession and the dispositions she employed in her work were not separate from the way she was outside of work. She thought her calm and unflappable approach had been learned from her parents, who were also rarely seen to panic, approaching everything in a laid-back manner. However, she stated that she often felt anxious and panicked 'inside', although the coping strategy she had learned meant that this did not register in her appearance or expressions. Interestingly, she did not see her 'outwardly' calm demeanour as a performance, explaining that in her view performances change and she never acted any differently. Clearly, she did not see her calm approach as a performance for patients and significant others that hides another, truer self, deep 'inside.' Rather, she saw it as being as much a part of herself as the anxiety that her coping strategy does not allow her to express. Because this strategy has been learned from the earliest years of her life, she did not see it as a performance put on for others; instead, she felt that it was an integral part of herself.

Not only did she use this aspect of herself to calm patients, she also employed it to support nurses who expressed panic and anxiety. However, it was also clear that her coping strategy had been reinforced by her professional training, or at least by her image of a professional nurse, as she supported the idea that nurses should always look ready to cope with anything at work. At least at this level, she is partly aware of her approach as a performance, using it to enhance her professional image.

Again, this nurse's activity can be understood as an example of confining emotion to particular times and spaces. In terms of emotional performance and presentation of self, she used the bodily techniques acquired at an early age to communicate calmness and control, while leaving anxiety unexpressed. This was registered only to herself as a felt bodily sensation that is not communicated to others. In that sense, it is confined to that imaginary space we believe to be 'inside' our bodies that we sometimes refer to as the 'deep' self. This bodily confinement of emotion has its counterpart in the spatio-temporal arrangement of the hospital ward, where there are no private spaces in which nurses can express their emotions. The nurse

from the surgical ward only remembered crying once at work, and went to the toilet to do so. Others reported that they have gone to the toilet or the sluice to cry. It is interesting that nurses often choose such places, for the toilet and the sluice are where potentially dangerous and contaminating substances are washed away. Emotions such as extreme distress could also be seen as potentially contaminating, as they could upset other patients and colleagues, and threaten the order of the ward. There is, then, an interconnection between the spatio-temporal arrangement of wards and the interactions that take place within them. Nurses are almost always on public display, and are expected to manage their emotions in order to maintain the correct interaction order within that place.

7.5.3 Space and time

It is argued here that space and time are integral aspects of this process, because particular moments as well as places are chosen to share information and emotion. The skilled management of emotions in the trauma room shifts nurses' emotions into a different spatio-temporal context. As one nurse described it, emotions are 'pushed to one side' so they are not felt until after the event:

> *'[The emotion is felt] probably after the patient has been dealt with. Whether they have died or transferred elsewhere then we get to talk about the event as such. What has gone on in here (the trauma room) we're able to air our views, we can talk about the event and thrash it out between us.'*

Here again a collective coping strategy is used within the community of practice, where nurses can talk between themselves about unwanted or unacceptable emotions in the past tense while denying that they feel them in the present, thus rendering such emotion talk safe. Again, this involves containment by pushing uncomfortable feelings into the past and thereby defusing them. For example, one nurse was only able to declare feelings of anxiety and fear in managing aggression when they are shifted to the safe spatio-temporal context of a different ward in a different time:

> *'I may have been angry then and [thought], "You're just buggering me about, what are you trying to do" and I might, I may have thought that, you know, "What are you trying to do to me, are you trying to bugger my mind up entirely?" Which I felt like sometimes, which I felt like that ... Maybe things have changed now.'*

Masking the emotions and engaging in a professional performance can be seen as a product of the socialisation of nurses into the management of emotion, but one nurse in A&E questioned the validity of this approach:

> *'Is it wrong to tell them, "You are making a big fuss over nothing. We've just had somebody in here that has died and I'm afraid that is the reason you have had to wait your turn"? I don't think it is wrong, no. Sometimes it benefits to voice your opinion, you are not giving away any confidential information to them. I don't see why we shouldn't ... let them know what is going on in the real world ... I think you've got to help them put it into perspective.'*

There is a line to be negotiated, therefore, between the containment of emotion and the suppression of negative feelings in an effort to appear professional, on the one hand, and communicating home truths, and consequently revealing part of the self, on the other. Yet as suggested at the beginning of this chapter, nurses tread a fine line in judging when and where it is appropriate to perform negative emotions and allow patients to see that they are annoyed with them. To do this without abandoning the image of a professional nurse or jeopardising an already fragile caring relationship, demands a finely-judged emotional performance. Interestingly, the manager of the A&E department did not believe in the stress discourses, claiming that the word 'stress' is a generic term which hides feelings of anger and frustration. Instead of claiming

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to be stressed, he felt that nurses should express the negative feelings behind the 'stress' label, sharing them within the community of practice rather than masking and containing them. He had clearly rejected the contemporary stress discourse, deconstructing it in a very practical way.

However, as Freund (1998) claimed, for most emotional labourers the shifting of emotions into different spatial and temporal contexts, along with the control of performances, creates extra stress for them. Keeping informational spheres apart and performances credible, along with managing the flow of information and communication, is physically and mentally taxing. Those in more powerful positions have 'status shields' protecting them from such stresses and are in a better position to defend their space and time. The less powerful are open to greater encroachments into their space and time, a contest that marks out the micro-political aspects of the work environment.

7.5.4 Identity: consciousness of kind

In the midst of all this, most nurses attempt to manage their emotions so they do not appear to panic or get irritable and angry with patients and their significant others. They must present an appearance of professionalism by coping with all demands the job throws at them. Management of the emotions was intrinsically bound up with their sense of professional identity and their notion of what was required to 'do a good job.'

The pressure for nurses not to get overwhelmed by the emotions and anxieties of patients and their significant others means they must manage emotions more generally. In this, humour was often an important emotion used to diffuse potentially difficult or dangerous emotional scenarios. The A&E nurses collectively described themselves as 'crack pots' with a discernible and, to an outsider, distasteful sense of humour. However, this was also used by the nurses to cope with both their own and patients' emotions. For example, patients' distress was sometimes managed by minimising the injury and making a joke. Humour therefore acted as an emotional release for both patient and nurse, transforming negative emotions into positive emotions, as well as helping to dispel embarrassment (Knight, 1996).

Another example came from an observation of a man going for a lifesaving, yet life-threatening operation. The nurse in charge of the situation allowed the family to accompany the patient down to theatre and a lot of humour was used to lighten the situation. The patient joked about whether it was safe to have so many people in the lift, the porter responding that it could take up to 25 people. The patient then remarked that they should find some more people, with the nurse joining in by saying they should make it a private party. At this point hysterical laughter on everybody's part replaced the family's grief about the imminent, and possibly permanent, separation from their loved one. This is a clear example of the use of humour to control and defuse a potentially overwhelming emotional scenario. By allowing the family to be involved in the preparation for surgery, the nurse gave them the opportunity to touch and console one another and to express their distress and sadness. At the same time, though, humour – instigated by the patient but encouraged by the nurse – turned these potentially overwhelming emotions into something more easily manageable. This is one good example of the numerous cases observed where humour was used by nurses to manage an emotional scenario or to fend off embarrassment.

A similar situation was found in the hospice in the case of one man whose death was imminent. In order to give him a private and peaceful death, the nurses moved him into a single room, which meant converting a male bay into a female bay. At one point during the rearrangements, the dying man, who was still conscious, was in the bay with three women. One nurse described what happened:

> *'I mean we laugh and we pull their legs and I mean even, there's [the patient] here dying and when we were moving him he was left in the four-bedded bay with three other ladies. We'd moved the ladies in first. I said,*

"John, they're not moving you out of here. Just think, your lucky day, three ladies around you and they're moving you out." And he looked at me and he smiled and I can't know what he said but I got some sort of a, a reaction was – "yes, fancy taking me out." Do you know what I mean? And yet the man is dying within two hours. So, you know, I think you do get a sort of – you do inter-react with them right up to the end.'

In this example, imminent death did not preclude the use of humour as a way of controlling the potential high level of emotion. Hospice nurses used humour a great deal, for example when giving a young male patient a bed bath, they did not shy away from the sexual banter he engaged them in. In fact the nurses said later that it made performing such duties easier when the patients were able to share a joke about it.

While many collective strategies for coping with stress were found, there were many instances where stress was dealt with outside work time. A surgical nurse stated she would not show emotion in front of others at work, and instead would 'let off steam' at home. Another nurse on the surgical ward put it in the following way:

'Well, really as far as the ward's concerned I've so much going on actually at home when I finish work … more often than – well unless I'm on late and then on early the following day, I tend to switch off, because I've so much to catch up with at home that [the] majority of it just slips, you know, to the back of my mind but … again, at work … I think my – it's just over years, I mean I don't tend to panic too much these days.'

This nurse's busyness at home distracted her from thinking about the pressures of work. When asked about nurses sharing problems at work and supporting each other, it was made clear that this did not happen in the way it perhaps should because of time pressure in working environments and how this limits interactions between nurses. In response to a question about whether staff talk to one another about stresses, the following was said:

'Not as much as they ought to really, no. I mean they have tried having ward meetings on here but … they don't really work because there isn't time … they've had them like half past two after the hand over. But there's only the morning staff and staff that are actually off duty that can go because the ones on late are usually so tied up. They can't actually get in. They've tried having them on an evening at somebody's house but then again you've got whoever's working late or nights can't get there anyway. At one time, years ago [with] a different sister, we used to have monthly meetings and get the consultants in, even if it was just for half an hour. And during the month we'd think of problems that we had, queries with doctors like preparations for operations whatever. And the thing was, half of these things, once they'd got sorted out at that meeting it cut down the stress for the rest of the month because you knew then what you were actually doing. Or if you'd got any worries, the views were aired and everybody was aware because half of the worries, if one person's got them a lot of people have got them.'

However, this arrangement stopped when the ward sister changed and the regular meetings were not continued, despite the fact they seemed to reduce stress. This shows the effect of management on the community of practice and the coping strategies of nurses within it, and how collective responses to stress are the most effective in actually changing the working environment. If management can strengthen the community of practice, there is evidence here to suggest that this can also reduce stress by fostering collective responses to worries and problems.

This was evidenced in the community of practice in the hospice where, perhaps because of the shared philosophy that gives a central place to emotions, there was a collective response to emotional stress. A morning meeting was held daily, attended by a wide range of

professions. In addition, a weekly meeting was held where time was set aside to discuss recent deaths. At the meeting observed, deaths were described in objective terms of whether they were good or bad – good deaths being peaceful and involving little trauma, bad deaths being 'distressing and traumatic.' While deaths were described in these terms in this more public arena, the nurses did not articulate their feelings or discuss how they coped with emotions. Rather the subjective display of emotion occurred immediately after the death, where nurses would cry together and support one another; they felt that this met their emotional needs better than waiting for a meeting, where emotional display was expected to be re-enacted perhaps more for the benefit of others than for the nurse. There was a strong sense in both the observations and interviews that the 'thrashing out' of emotions was limited primarily to members of staff who had directly experienced the emotive event and, secondly, to the wider community of practice. As previously described, there was strong resistance to the input of outsiders, such as counsellors, psychologists and clergy, for debriefing and support. This again reinforces the role of emotions and shared experiences in creating and maintaining the boundaries of the community of practice.

However, while the expression of emotion was encouraged in the hospice, this does not mean emotions are not carefully managed. Again, nurses did not have a private space to let go of emotions inappropriate to express in front of the patients and others. One nurse in the hospice commented:

> *'There's nowhere private for the nurses to go, nowhere which is our own, where we can go if we want to have a cry. You end up rushing to the toilet if you want to cry.'*

This illustrates how, even though encouraged to share emotions, nurses had to maintain some control in order to keep their professionalism and support patients and relatives. The management of emotion therefore involved fine judgements about the appropriateness of emotional performances, the strength of emotional expressions and the time and place in which to show them. Even when nurses got close to patients and their families there was a feeling of restraint upon the open expression of emotion, as illustrated in the following quote:

> *'I don't think I've ever sobbed in front of any relatives ... but I mean my eyes have watered once or twice as with Betty ... I used to get support from Betty's partner really I suppose and her sons ... because we'd ... I suppose we'd got close.'*

Here the nurse controlled emotional performances in front of the patient and relative, although she admitted to getting support from the patient's partner and sons. This leads to the perceived danger of becoming too close to a patient and their relatives and so losing professional detachment. In highly-charged emotional situations, where a nurse is caring for someone who is gravely ill or dying, she or he can become like a member of the patient's family. In such situations, nurses in the hospice relied on each other to help them maintain some distance from these emotional entanglements. By acting as a support network, the community of practice protected against nurses becoming overly involved with patients or their relatives.

However, this depends on the strength of the community of practice – where this is weak nurses will be left more to their own devices in coping with emotion. A nurse at the hospice illustrated succinctly the way nurses use their colleagues as a support network and the division between work and home as being a cut-off point for emotions to do with work. However, something else is added –the coping skills the nurse learned from bringing up a family:

> *'I think so because I think we get a lot of support and I think we get so much support from each other here that you can talk about it and if your fed up and – perhaps we're all different. I mean we are all different I, but I find whether it's because I'm older and I've brought children up I find I can, I can disassociate myself. I can sort myself out, I can cope here and I can help other people cope and I go home and I mean if I was fed up I'd*

chat to somebody, you know what I mean. If I said "oh that's been a particularly awful death, lets go through it or is there anything we could have done better than we did"? But I think on the whole, I do find I can more or less switch off and go home.'

Here, she used the experience of bringing up her children and the ability to 'disassociate herself' in her emotion work with patients, although she did not say how this developed in looking after her children. Nevertheless, this is an example of what Bourdieu (1990) would call a 'transposable disposition' –an acquired habit or ability learned in one setting and transferred to another. Again, dispositions that women develop in order to cope with managing a family are transposed into the workplace. Also, motherly instincts are identified with coping and supporting others through traumatic incidents, along with the ability to compartmentalise emotion. This is evident in the same nurse's response to a question about controlling emotion during a particularly distressing death the previous week:

'Well, I think sometimes it's difficult but there again I think at the time I often find – I know Claire [nurse] was upset and I think probably my motherly instincts take over and I would look after Claire and sort the "rellis" [relatives] out and sort the patient out and by the time it's all sorted and done and dusted I think, "well he's at peace." So perhaps the emotions don't then have time, you know what I mean.'

It is interesting to note here that the nurse who was upset when dealing with this patient was told, 'You go off and sort someone else out' when she became what was judged to be over-emotional. And then there was always humour to dispel any lingering sadness:

'Well you see, we say we'll laugh with them but we'll cry with them as well. You know what I mean? There'll be as much laughter as there are tears really here. Because people say, "isn't it doom and gloom," so we say it isn't doom and gloom at all.'

The various communities of practice and contexts in which nurses work, plus the level of emotion work engaged in, resulted in nurses differentiating themselves in terms of care-giving characteristics. Again, identity and coping strategies varied across different specialisms and contexts. For example, one A&E nurse described how, 'we're not your caring, brow-mopping nurses.' In this way, nurses in A&E separated themselves from other nurses, by assigning themselves a collective identity with definitive characteristics. The nurse quoted above continued to explain that this 'hardened' attitude was reflected in the way he communicated with people, by avoiding 'nursey' talk in his attempts to normalise what can be a highly emotive experience:

'Patients are very, very anxious and they don't want prissy nurses coming along and talking nursey talk to them … talking in low voices. They want normal people. And you want to make their experience in here as normal a part of their life as you can. I talk to the patients here like someone who I've met in the pub or in the street, I don't relate to them any differently here. Because they are people and I think they need a normal conversation.'

However, this would be very different in the hospice setting where there was not the same value placed on working at speed and dealing with whatever is thrown at you. Here, nurses clearly valued time with patients and their significant others, and were keen to promote empathic relationships. This is an illustration of the way in which, in practical everyday relations, the coping strategies and styles of nursing vary enormously within different communities of practice.

7.6 Conclusion

This chapter has sought to explore some of these coping strategies and show how emotion work varies between different communities of nursing practice. Yet just as there were similar sources of institutional pressure across all these communities and contexts, there were similar solutions to some of the pressures and stresses of nursing. For example, stress was considerably reduced when nurses felt they had some control over their time and the spatial arrangement of the wards. Control over workloads was also an important element in stress reduction. A reduction in the power and status hierarchy, both within nursing and between nurses and other professionals, also reduced stress as this tended to give more value to nursing care and some level of autonomy and space for individual decision-making for nurses. Last, but by no means least, it was clear that stress was reduced in those communities of practice where nurses were allowed to develop a strong sense of collective identity and to give one another emotional support. This lends weight to Newton's (1995) argument that the individualised nature of work and coping in the contemporary world create many of the problems that are reflected and refracted through the stress discourse. This is true of nursing. However, the strong community of practice that can develop between nurses means that within the profession there is an excellent basis for a solution to the problem of stress through the development of collective coping strategies.

8.1 Introduction

Chapter 7 discussed the *management* of emotion in emotion work with patients, this chapter discusses the *use* of emotion by nurses; how emotion is managed for a particular effect in a therapeutic relation and how it is used as one of the bases for clinical judgements. Like all aspects of nursing discussed so far, clinical judgement only takes place in particular communities of nursing practice; it cannot be abstracted and studied as a rational, disembodied process in its own right. Instead, it involves many aspects of nurses' skills employed in the community of practice.

Effective communication is central to clinical judgement because it is the basis on which the nurse can make a proper assessment and decide upon the necessary treatment. However, the process involves more than communication and social skills; the nurse must also be an interpreter, capable of reading all the signs in a particular situation and responding appropriately. The response to the vital signs in any context of patient care is determined largely by the nurse's experience and what he or she deems to be effective care.

This research has shown that when nurses employ evidence-based practice, they draw largely on evidence formed by their own experience. They do attempt to put academic research into practice, yet this is always done in an eclectic way – only those parts of various theories that work well in caring for patients are used and incorporated into everyday practice. Theory is tested through experience and adapted to practice. Also, in clinical judgement, a major role is played by intuition – judgements made so quickly that they bypass rational thought processes. Intuitive judgement involves doing something before working out why that is the thing to do. However, observations and data gathered in interviews with practitioners and educators suggest that intuition is not necessarily a special form of judgement in itself. Rather, intuitive judgements and actions are synthetic processes that involve a rapid reading of the situation, blended with experience of similar situations and an emotional sense of what needs to be done. It is clear from the data that intuition and experience go hand in hand, so that the more experienced a practitioner is the more they are able to act intuitively.

While nurses in the study often claimed that skills such as communication and intuition could not be learned, they can be acquired and strengthened through embodied learning in practice. The basis for clinical judgement and intuition may be life skills that a person brings into practice, which are built upon in the creation of a professional identity. Life skills such as an ability to communicate well are the foundation upon which professional practice and identity are created. This means most nursing skills are acquired in practice through performance-based learning. This is not to denigrate the role of formal education or skills updates; these are necessary for reflective practice. Formal education helps nurses to examine these habitual practices and to discard them if they are found to be of no use. Yet all nurses learn through situated practice – joint activities within a community of practice – and many practices are acquired from more experienced nurses. Acquiring the skills of a professional nurse, then, is an embodied process that takes place within a community of practice, where the less experienced learn through interactions with others. Only in the context of the community of practice can clinical judgement properly be understood.

8.2 Cognition and emotion

One issue this research cannot avoid addressing is the recent debate in the nursing literature about the role of cognition, emotion and intuition in clinical judgements and, linked to this, the question about whether what makes good nursing practice can be quantified and

assessed. The debate is neatly summarised in the disagreement between English (1993) and Darbyshire (1994) over the place and function of intuition in nursing. Darbyshire is an advocate of Benner (1984), who suggested – following Dreyfus and Dreyfus (1986; 1987) – that as nurses become more experienced, they rely more heavily on intuitive judgements than rationally-based cognitive ones. The expert nurse practises on the basis of her feel for the situation rather than any explicit criteria which can be quantified or measured. For English this approach creates more problems than it solves because 'intuition' is a notoriously slippery concept, hard to define let alone quantify or measure. Using Benner's model, therefore, it is impossible to say when the nurse has reached expert level, nor how to recognise and acknowledge that achievement; it is also impossible to instruct new members of the profession on how to reach expert status. English suggests the use of cognitive models of perceptual process that can account for seemingly 'intuitive' judgements in terms of models of memory and feature detection. These models can be used to develop explicit criteria on which to assess nurses' professional development and to instruct novices, making educational and career progression more open and understandable.

In reply, Darbyshire claims that English is basing his work on the crudest form of positivism and aiming to quantify and measure what is intrinsically unquantifiable and immeasurable. Furthermore, the desire to quantify nursing expertise has a political element to it, for: *'the familiar appeal that our new understanding of expert practice be forced back into the cognitivist brace of "precise definitions and descriptions of patient care" and "criteria by which nurse experts were measured", [is] in the name of the new god of prediction and control – quality assurance'* (Darbyshire, 1994: 757).

While the language of cognitivism will be more appealing to management ideology, this is not its main drawback. Concern with a cognitivist reading of these research data is twofold. First, many cognitive studies of nursing practice and clinical judgement lack ecological validity. For example, Crow and Spicer (1995) studied nurses' decision-making processes using sort card tests to try to understand the cognitive frameworks nurses use in deciding upon appropriate care plans. However, in such tests nurses are isolated, and complete the test in a neutral environment with only the cards to deal with. Can this really replicate the decisions nurses make every day, working with others in the community of practice, often facing crisis situations in which they may feel a range of other emotions? This study has tried to meet standards of ecological validity, studying nurses within the community of practice and developing explanations on this basis rather than on assumptions about mental structures said to underlie everyday activities.

However, like Benner's work, this study can be open to cognitive readings. Without attempting to replicate her findings, it has emphasised the importance of capacities such as pattern recognition and the observation of visual cues. If such capacities can be encapsulated in a cognitive frame of explanation, it is within the cognitive approach known as 'fuzzy logic' that the data seem to fit. Rolfe (1997) describes fuzzy logic as operating in accordance with rules, but these are too hazy or imprecise to be expressed verbally. Also, different rule systems can operate simultaneously, but to different degrees. How these rules work together depends on the particular situation so that, rather than arriving at a decision based on precise logical calculation or categorisation of cues or events, we settle for a 'fuzzy weighted average'. This accounts for the subjective experience that we make decisions and judgements by 'feel' rather than logic. So an expert nurse's decisions will be based on rules drawn from knowledge which is comprised of formal learning, but also from experience. The fuzzy weighted average is arrived at by weighing up scientific facts and theories with previously encountered situations, along with personal knowledge of the patient.

According to Rolfe, such fuzzy logic works by 'abduction' rather than deduction, the latter being the logical method employed in classical reasoning. As noted in Chapter 4, abduction is a form of reasoning proposed by the 19th-century pragmatist philosopher Charles Pierce, who argued that: *'whereas formal deductive logic starts with a general statement or theory*

about the world, such as "all men are mortal", or "pre-operative information-giving promotes healing", in real life we usually start with a problem concerning an individual, such as "is this man mortal?" or "should I give this patient pre-operative information?" Abductive reasoning therefore turns formal logic on its head by beginning with the conclusion and arguing backwards to the premise' (Rolfe, 1997: 1073).

Perhaps Rolfe is wrong to say we begin with the conclusion and argue back to the premise: more likely we confront a situation, sensing from this our conclusion and then argue back to the premise. So a nurse's decision about whether to give a patient pre-operative information will depend on her understanding of that patient and how they are likely to respond, then working back to the reason for that decision.

However, this raises the second problem with cognitive science, that such abductive and fuzzy decisions are made according to rules, meaning the important element of communication and emotion is left out of the picture. Is it only rules – albeit of the fuzzy and multiple type – that play a part in clinical judgement? This research suggests not. What was observed fits more with Scheff's (1990) theories of abduction and intuition. Scheff also follows Pierce's notion of abduction, but for him abduction indicates not only a 'backwards' process of reasoning, it also involves observation being balanced with imagination: one not only observes or lives an event and uses abductive reasoning to work from a conclusion to its premise, one also uses imagination to reach an understanding of the situation. Furthermore, our understandings of a situation and how we use our imagination or intuition to think about it is a process based in the meanings we bring to everyday events and interactions, which is itself based on the way we communicate with others and attune to them emotionally. In other words, prior to imaginative understanding or intuition there is communication and attempts at emotional attunement. For example, in deciding whether to give pre-operative information, the nurse has the general rule that such information is good and reduces anxiety and discomfort. However, she also knows that where anxiety levels are already high in a patient who may have a phobia about hospitals and treatment, pre-operative information may be counter-productive. The only way the nurse can decide between these options, or what level of information to give, is by having knowledge of the particular patient and their emotional state: this can only be done through communication, emotional attunement and empathy. Only on this basis can a conclusion about how to treat this particular patient be made and the process of abduction begins. So involved in any decision-making process in nursing there are not only cognitive reasoning processes, but also communication and emotional attunement (or the lack of it) between nurse and patient. This is something that both cognitivists and anti-cognitivists ignore.

Communication – which involves interpretation, not just of others but of the total situation – is at the basis of many skills involved in clinical judgement and, whatever cognitive processes are also involved, these should not be seen in isolation of human interactions and the attempts to create emotional attunement.

8.3 Clinical judgement

8.3.1 Reading the signs

A central aspect of clinical judgement, then, is its close connection with interpersonal communication. This includes the concentrated listening that often yields deep understanding and sudden insight, as well as the observation of visual cues within the situation, including the body language and appearance of others. One could therefore see the nurse as a skilled observer, who interprets the situation not from a disembodied canon of knowledge, but from their embodied skills that are engaged in the process of patient care; skill is not separate from the nurses' identity. In clinical judgement the interpretation of visual cues picked up from observing the patient is vital to forming an assessment, as seen in the following interview with a CPN.

Interviewee: *'I mean I would be fairly confident in my own ability to go to people that I've seen for a number of years or more than 12, well more than 6 months, 12 months upwards and within you know just from that sort of visual check, could be quite accurate in assuming and predicting how they are. And, so you know it isn't necessary to stay half an hour or 45 minutes or whatever it is.'*

Interviewee: *'And how can you make those rapid decisions?'*

Interviewee: *'I would say that the sort of physical presentation of the person on that day. Um ... you know that way that they look. Um, sometimes the way they dress, the way they carry themselves, you know when they invite you in and they go and sit down, I think "Oh God! Oh dear." And sometimes people will just open the door and I've said, "Oh, as bad as that?" and they went "Yeah!" But that was a manic depressive lady, who when depressed wears her nightie, so you know the minute she opens the door and she's in her nightie that this is sort of reflective of her mood going down and she hasn't had the energy or the motivation to get dressed.'*

The use of visual observation as a source of clinical judgement was also strongly displayed. As one nurse remarked, *'It comes down to observational skills. Rather than just waiting for a verbal communication off the patient, you are actually looking at him thinking; he is not well, he is pale, he is clammy.'* In the A&E department the triage station directly faced reception so the triage nurse could see patients as they come in. This made it possible to make a rapid assessment, sometimes before patients even speak to the receptionist. From this vantage point, the triage nurse may also decide which patients need to be assessed most urgently.

In the case of a child brought to casualty after crashing his pedal bike and hitting his head, the triage nurse used both observation and communication to make a rapid assessment. The child had a prominent injury to his forehead, was suffering from headache and neck ache and felt nauseous. The nurse asked him whether he was suffering from any other pains and he complained of stomach ache, but added 'I always have stomach ache.' This alerted the nurse to something perhaps more serious and he immediately became concerned more about the abdominal pain than the head injury. After an hour, the boy began to vomit blood, indicating that he may have internal injuries. Although examination showed this was not the case, this is still an example of the how reading the signs can alert nurses to seemingly less important symptoms that may be significant.

As stated earlier, this could be explained by cognitivists in terms of pattern recognition or the picking up of cues, yet this explanation ignores communication and the interpretation of meaning that is so vital in clinical judgement. It is this interpretation of meaning, achieved through communication, which allows the nurse to accurately read the signs in any situation and come to an ecologically situated judgement.

8.3.2 Evidenced-based practice

Clinical judgement also draws much of its power from experience, which is blended with visual and auditory observation in the assessment of patients. This was clearly seen during in the case of a child brought to casualty having injured his leg. The triage nurse immediately noticed that the child looked pale and was not as talkative as other children in the unit. In seconds the child was taken to a cubicle to be examined. It turned out that he had a systemic infection from his foot into his groin area and was acutely ill. When asked about how he had made this assessment so rapidly, the triage nurse claimed that he knew that if children were quiet there was usually something seriously wrong and that the child's quietness had rung alarm bells.

As a nurse in A&E remarked when talking about assessment of patients:

'Initially, it is a visual assessment you are making on the patient. What they're looking like. What I try to do I try to communicate with the patient. Not generally asking them questions just a simple hello to see if they respond to me and what response I am getting. Are they looking at me, are they making any comments or talking; do they say "hello" in fact. And then obviously what I do then I am watching the patients whilst I am getting a hand-over from the ambulance crews. So I am getting all this information that is coming at me: visual stimulation and everything that is coming. And from my experience I am making decisions about what is the matter with the patient and where they should be channelled ... I am making a decision as quickly as possible with the information that is given to me. And from my experience I have had in the past, the information that comes through helps me to channel the patient into a triage category ... where I know I need them to go.'

The above quotation illustrates all the different elements involved in clinical judgement. It also shows how experience is one of the key elements central to nursing practice, especially in terms of arriving at a diagnosis of the patient's problem and how to deal with this. This would appear to be why, when practitioners talked about the 'evidence' on which clinical judgements were based, most tended to refer to their experience rather than to any body of academic work. The research therefore supports Schön's (1983) idea of the 'reflective practitioner', who is constantly reflecting on their experience and expertise. This does not mean that academic work does not filter into nursing practice and change the way nurses work; it does mean, however, is that in everyday decision making, nurses tend to draw upon their experience of practice, even if this has been moulded in various ways by research based literature, or by ideas encountered on a course.

8.3.3 Intuition

Intuition is often defined as the direct perception of things as they are. It is a form of knowing that seems to bypass rational, cognitive thought processes and appears in consciousness as unmediated understanding. Because of this it is felt by the person who experiences intuition as an 'inner' understanding that often runs contrary to accepted social knowledge or to the rules, conventions and protocols of a community of practice. There is, then, something about intuition that runs couhter to accepted social conventions. However, this does not make intuition asocial and individualistic; it has many sources in embodied forms of practice, involving sensation, emotion and thinking, and is embedded in our connections to others and to the situation in which we are located.

Intuition also involves more than the rational mental processes used in ordinary problem-solving. It involves a synthesis of visual, aural and tactile perception with emotions and conscious understanding. It is therefore a more embodied form of knowing involving all bodily processes that are engaged by being in the world. What intuition displays is something Scheff (1990) called 'ecological validity', the ability to solve a problem or reach a decision taking into account the complexities and ambiguities that make up any human situation. This is a form of thinking that computers were initially incapable of, as they worked in purely rule-bound ways. To overcome this problem the system of fuzzy logic was developed in order for computers to follow more closely the patterns of human thinking. In order to quickly form connections between the many, varied and ambiguous elements of any human situation, one must rapidly synthesise these elements into an understanding of the meaning of that situation. In making intuitive judgements in nursing, observation, communication and experience work together. As Scheff points out, humans can rapidly form such connections, whereas computers cannot, because humans form associations by comprehending them emotionally as well as rationally. Indeed, emotional understanding may be the basis on which intuitive judgements are formed. Association is therefore a total process, involving both emotional and intellectual

understanding, in which connections that are formed impromptu for purposes immediately at hand may be more emotional than rational. This is an important element of intuition and accounts for the speed and breadth of intuitive knowledge.

However, experience also informs intuition and is an important element of it. Experience can give the confidence to trust intuitive knowledge and to use it to deviate from standard practices when the necessity arises. Not every case fits snugly into the routine and well-ordered protocols, as each patient may display their symptoms differently or present them in idiosyncratic ways. The ability to watch, listen and pick up details that would be incidental to the purely rational mind, is an important part of intuitive knowledge. But this requires experience to know what to look and listen for and to trust what one is seeing and hearing. In many ways, intuition flows as part of embodied, skilled practice: it is a non-dualistic integrity that involves doing 'as' the world rather than thinking 'of' it (Burneko, 1997). In other words, intuition does not aim to 'represent' things as they are; it actively engages with them and changes circumstances. It is closely related to both imagination and creativity.

Intuition is therefore an holistic understanding, the bringing together of many aspects of a situation so that one can better understand the whole. This is why intuition seems to bypass rational thought processes, because it does not proceed through stages of logical induction to reach a solution, instead perceiving it at once or as a gestalt. In fact, one could say that the intuitive practitioner is practising an interpretative art (Harbort, 1997): they are interpreting the cues they pick up from observation and communication.

That intuition is closely bound up with communication can be seen from the following section of an interview with a nurse on an acute psychiatric ward. The nurse was talking about reading a patient's reactions to judge the effect she was having on them and to work out what approach the patient would be most comfortable with. She was not sure exactly what composes the skills she was using and was certain that these are things that cannot be taught in any formal way. This was discussed in relation to knowing if, and when, one can use touch with a patient.

> Interviewee: *'I'm not frightened of touching patients, you know like offering a hand of support or doing that. But I have to be careful, it's timing, it's when it is right and when it feels right and when you feel that person would respond well to that, that support. Somebody touching your knee or gently patting you on the shoulder or something, it has to be done very carefully, because not all of us like to be reassured in that way. And again, it comes down to reading, what's happening in your interaction and where she is, if she is comfortable. So even though you may, may offer a friendly pat of reassurance on the knee, I tend to be a little hesitant when I do it and see if she's comfortable with it. So you're reading everything, there's a lot of information going in.'*
>
> Interviewer: *'How, I mean, you've talked a bit about how you judged that, about the appropriateness, use of touch. What does it come down to, because when you're with a patient and you're there in an interaction you've just rationalised how you might break that down, but it's probably a very quick decision when you decide to offer a hand to somebody or to put your hand on their shoulder or to give them a hug. So I just wonder how, how you make that judgement in that interaction?'*
>
> Interviewee: *'... It's like almost, I think it works on two planes in that it's almost a comfort zone. There's a lot of dynamics that, that are going off. There's how she's then speaking to you, how close her body proximity is, you know, if she's coming forward. There's lot's of little bits within the body language, eye contact, when somebody's eye contact gets that little bit more, I wouldn't say fixed, but they're a bit more sure and they feel that little bit more comfortable with you. The problems or conversation*

content, what they are particularly talking about at that time, usually can give you a cue that they are comfortable with you to talk about such things. Because I think, if I remember correctly on that interview, that conversation at that point … she'd opened up a few things, concerns and I think by that time, at that point I felt she needed a bit of extra reassurance and it felt right to me both in my reading of the situation, reading her body language, listening to what she way saying. My comfort zone it's almost like a, there's also a good feeling that yes, this will be OK, this will be accepted as well. There's something …'

Interviewer: *'Intuitive or instinctual?'*

Interviewee: *'Yes, there's something that isn't learned and you can't put yourself, put your finger on it. I think there's a lot of things within communication that aren't … but I'm sure that people who do communication would say "oh yes, there's a word for, for what you've done there" and things but I think a lot of it is … automatic processes.'*

What this nurse described as automatic processes are exactly some of the elements described as intuition. There is the rapid observation and continual reading of body language to ensure that the patient is comfortable with the nurse's approach, along with concentrated listening to the patient's verbal responses – her concerns and worries – and continually 'reading the situation.' Here is an example of the practitioner as interpreter discussed earlier, noticeable in her constant use of the term 'reading' to refer to the way she comprehended the situation. Although the interviewee did not use the term intuition, she acknowledged this when it is mentioned, saying she was not sure about all the processes going on while engaged in this form of communication. However, she was sure that such intuition cannot be learned, although we would need to distinguish between formal and informal learning in this respect. Perhaps intuition is something that can either be learned, or at least reinforced, in practice.

The same nurse also referred to a common experience in intuitive knowing, a 'gut feeling' that something is not quite right, even if one cannot rationalise the feeling to explain exactly what may be the problem. After talking to a patient the nurse explained that:

'And you're thinking "right", and sometimes that you come away and you've got like a little alarm bell ringing in your head or your gut feeling goes again and you find that you're processing it all. Then the next day you're back to the conversation, you're going back to go and talk to the person and you've got this little niggling question that you're dying to ask, because they've brought it up in the conversation but at that particular point either it wouldn't have benefited your therapeutic relationship to ask at that junction to ask "what do you mean", go explore, that type of thing. Or you realise you missed the signal and you missed the point to pick up and go with it.'

Again there is the question of looking for the signal that something may be wrong, something the patient is not talking about; if the nurse does not pick this up at the time the opportunity to explore it is missed. Either the signal is missed or something else in the interaction inhibits the nurse from exploring her concerns. Signals and cues exist in a situation where a nurse interacts with a patient, and these trigger intuitive insight. Also, in the quotation above, reflection is involved, although this tends to come into play after the actual interaction when the nurse is analysing the situation. However, in reflection, the opportunity to explore the area of intuitive insight may have disappeared.

In the community mental health setting, a nurse talked of intuitively knowing what kind of personal approach particular patients will respond to and what may alienate them:

Interviewee: *'You know it's horses for courses, there are people that I perhaps have come across and intuitively you recognise that they are going to respond better to this sort of tactic [adopting the role of therapist] than perhaps a very open friendly and very jovial, jokey whatever. You know because some people might perceive that as belittling the symptoms that they've got or what they're saying is happening and I suppose for someone to make light of it they would be quite offended with that, you know. But to them it's a very serious thing, um, I haven't come across many people but have come across one or two and you know it's a case of, I mean, I don't know how you recognise that but it's this sort of intuitive thing that they won't respond to perhaps what I would normally do. And that they do require a more conservative sort of, you know, intense clever looking sort of therapy.'*

Interviewer: *'I mean you mentioned the word "intuitively" which is quite an interesting word because you know we say that our nursing practices are based on research and yet I guess that we can all say that there are times in our relationship with clients where we've had intuitions or intuitive moments. So it's not all purely research, there is something else there and I often wonder what that's about where intuitions come from. Do they come to us as people or as a nurse or ...'*

Interviewee: *'I think, um, one lady that I saw, I think intuitively that came from me as a person that she would not warm to me as a person, if I was my sort of normal self. Well I think it might have been a bit of both, the sort of nurse in me and the person, where I thought, "oh no, this is a definite you know by the book assessment".'*

In such instances, a rapid check on the patient's reactions determines the approach adopted by the community nurse. Here is the kind of emotion work between nurse and patient discussed at greater length in Chapter 7. When the nurse above said these skills came partly from her as a person and partly from her as a nurse, these skills are learned in everyday life and get transposed into the field of nursing where they are drawn out, utilised and built upon. Again, this is another instance of transposable dispositions and how they are vital in communities of nursing practice.

Intuitive judgements, then, are a combination or synthesis of many different bodily processes. Visual observation is combined with verbal communication, and the information is then filtered through experience to make rapid decisions about what is wrong with the patient and how they should be treated. As a staff nurse claimed:

'I think common sense and intuition plays a part. But whether intuition comes with long-term experiences, a building up of experiences, whether that's what I class as intuition or not ... having some inner knowledge of what's gone on before, what the patient's likely to present with, I don't know. Yes, there is some intuition, certainly. I mean, you can see the difference from somebody that comes down that has only been down here a few months compared with somebody who has been here long term. The judgements are made a lot quicker.'

When performing such rapid assessments and making such quick-fire judgements, nurses are aware that they are not just relying on thought processes, on a rational categorisation of patients. However, they are less certain about what skills are involved in these processes, other than experience, and seem sceptical that any form of intuition can be learned. That intuition is emotionally rather than rationally based can be seen in the fact that intuitions are often described as feelings rather than knowledge. This often takes the form of feeling that something is not quite right, as a nurse on the medical ward indicated:

'And probably, just by your assessment of the patient, sometime you just know there's something not right there, they're probably very quiet and you'll go back and say, "Are you alright?" And that's maybe when they confide in you.'

This, however, is linked to good skills in relating to people, something that not only expert practitioners possess but students can have as well:

'I think some students, or some people are just good at picking up when a patient's not happy, and they will go and talk to patients.'

However, relying on intuition in a medical setting is often risky. In A&E, for example, nurses were aware that they often ran risks in intuitive assessment and in prescribing treatment on this basis. However, in their view the risks were based on sound judgement and years of experience in having to make rapid decisions.

8.4 Skill acquisition

8.4.1 Situated learning

For nurses, skill acquisition is largely a process of embodied, performance-based learning in clinical settings. This does not mean that academic programmes play no role in the acquisition of skills; they often set a framework for nurses' subsequent experience and provide the knowledge and ideas through which to reflect on their practices. Knowledge and skill are intimately related within the nurses' professional identity. It is simply that academic knowledge alone is useless without the experience of embodied, situated practice through which aspects of knowledge can be put into practice. As seen in Section 8.3, experience is one of the prime sources of knowledge that informs nursing practice. Indeed, some nurses studied, nearing the end of their careers, still choose to develop their skills through practice in clinical settings rather than by formal education. However, for all nurses, there is no substitute for learning skills by performing them within communities of practice, in joint activities with other nurses and professionals. A nurse in A&E summarised this point well:

'I think the best experience that you can pick up is through the shop floor rather than any type of course. A course sets a base for your experience that you get in the department and that you are picking up from other people as well.'

Section 8.3 also demonstrated that many nursing skills are based on transposable dispositions, or life skills, that people have developed in other settings. These are then brought into nursing and form a basis upon which other skills are built. However, there is scepticism within the profession about whether such skills can be taught to students, certainly through formal learning. This is certainly the case when it comes to dealing with people. As a nurse in A&E remarked:

'This is what we do all day isn't it really – deal with ill patients and their relatives who are very anxious. And they need some basic skills in doing that type of thing, which you can't learn from a book or have a lecture about.'

Yet while it is clear that such skills cannot be learned in any formal, academic way, there is an acknowledgement that they can be acquired within the community of practice:

'What you've got to do is see someone else dealing with it and how they are dealing with it and you reflect on your own feelings ... what has gone on in your life as well. You know, relate it back.'

This illustrates the importance of role models, the way that nurses learn from modelling their performance on others. However, this is not done in a straightforward manner, as suggested by social learning theory. Behaviour is not learned only by modelling and reinforced by

subsequent experience; rather, performance is modelled on others, yet only after it is related to one's own life and feelings. Like a good method actor, for the performance to be credible it must be related to significant life events and the emotions these have created in order for the performance to become one's own, not just the imitation of another person. In this way, forms of practice within the community are embodied and restyled to give them authenticity and credibility, so that they can be used to build meaningful relations with others. This also means that people do not reproduce the style in a mechanical way, but can respond to individuals in each case with its own unique circumstances. This was reflected again in A&E:

> *'What we try and do is have one of the junior nurses working along with one of the experienced nurses to see how they deal with it. But you can never ever say this is the way you should do it, because every case is different.'*

However, along with the gaining of experience in practice, the A&E department also had an induction programme for new staff.

> Interviewer: *'How do nurses once they come into A&E talk about skills? How do they learn the skills once they're here? I mean again is that mainly through experience.'*
>
> Interviewee: *'Its through experience and we have a good induction programme for new staff entering the department. And one of the first things that I find very difficult at first is all the minor things. It's the same with junior doctors when they come, what do I do with a broken fingertip? How do I do a fingertip dressing? What do I do with a fifth metacarpal. You know, simple injuries that they find difficult, the different dressings and procedures for that.'*
>
> Interviewer: *'Is that because there is such a wide variety of…'*
>
> Interviewee: *'Yes there is such a wide variety of those type of things yes and so the senior staff nurses, I know its old fashioned I know. But we have what we call a minor injuries checklist. And we have it printed out and every new member of staff gets that and they work through all the different things.'*

So, as in the model of Dreyfus and Dreyfus (1987), beginners in A&E must follow rigid protocols outlining procedures until they become experts, at which time such protocols and basic skills become embodied and taken for granted – a basis upon which more creative and intuitive practice can be built. However, not only beginners can learn in this manner – experienced staff can pass knowledge to each other through situated learning or learn together as in the NHS training department's Health Pickup Scheme. This was used in A&E:

> *'… because you do it in your own department. It's a six-month project. You do three month open learning thing in a group in your own patch. The first one we did the package was called 'Communicating With Patients'. And out of that we came up with the bereavements packs which we've developed here. So we did all the reading about communication. Did all the role-plays and things, and then the project pack we put together.'*

Here, all staff are involved in a programme of situated learning and in developing a pack based on their own programme for others to follow. This is just one of many ways in which staff observed in various situations passed their experience to others. However, one key element in situated learning is working with 'masters', those with more experience, and developing skills in joint activities with them. This can take the form of anything from asking for help with technical matters to taking others as role models. As one CPNs said, in reference to anxiety management:

'Um, and those were mainly, you know, things like anxiety management that we'd done on the ward but never, sort of, a formal package of doing them. It was just what skills you'd picked up, you know, what things you knew other people did that worked. So I suppose you would mirror what other people did and use the things that worked well and discarded the things that appeared not to work as well.'

Again, the modelling of behaviour is used to develop skills, not so much in terms of copying actions but a selective adoption of things that appear to work well.

8.4.2 Life skills

One common life skill often stressed to the researchers is that of parenting. This develops the caring skills and dispositions directly transposable into nursing practice. For a nurse in the hospice, returning to nursing after bringing up children, this experience obviously helped her resume her nursing practice:

'Well I felt my skills as a – having been a mother of three children, you know, I found that was helpful. I think a lot of it is just basically experience of life.'

The other main life experience used in caring for patients and their significant others is bereavement. A nurse in A&E used the experience of his father's death to identify with and counsel people through the loss of a loved one. This makes it more difficult for younger students to deal with such cases, as they may not have the life experiences to bring to them. As a nurse on the medical ward remarked:

'I mean, they're quite young most of the students we get. I mean, you get one or two more mature ones, they seem quite good, the more mature ones. But I suppose they've got the, they just take all on board and then they'll come back and say to us, you know, "I think so and so could do with a bit more help, or his family would like seeing to." So at least there's somebody there for them to pass the burden on to.'

Despite this view of mature students, over-generalisations should be avoided. Not all mature students will have these life experiences, while others may be unable to use them in a way that will benefit the patients. Similarly, some younger students will have some life experience or will be gifted with enough empathy to be able to understand and relate to a patient.

8.4.3 Education

One common theme often encountered when discussing education with nurses was the difference between academic work and the skills needed in nursing practice. The views expressed below are not atypical:

'Any essays that I've written were sort of ten years ago and I couldn't sort of get it into my skull that what I thought mattered and what I could validate from my own sort of experience you couldn't put into an essay. Just on its own and unsupported, it might be true for you, but um, I just found it a bit demoralising, but I had to search for other people who had similar ideas, that could support and validate what it was that I was putting in this essay. Um, and I've done the routine sort of "Gestalt dreams, weekend work" and sort of a lot of in house things, um, but those will be the only two ENB courses that I've done – the violence one and the teaching and assessing.'

Here can be seen the difference between experiential and research-based knowledge and the difficulty in bringing the two together. When entering education nurses must learn new skills that have little relevance in the delivery of care – writing essays and assignments,

written exams – but in the process learning to back up one's opinion with research. As the nurse remarked, this allows practitioners to keep up with new developments and to put these into practice, breaking old habits in the process. She went on to say:

> *'Um, I think as I said to you before the more courses you do the more you realise the less you know and it's a vicious bloody circle isn't it! Um, but things are ever changing and, I think as I said before, you know, particularly with the first three modules we covered as part of the diploma were research awareness and, yes, I've read um, research summaries before and perhaps the recommendations from those I would try and implement within my working practice. And if they appeared to work better than other things that I've tried then I would sort of retain those skills if they were fine on paper, but putting it into some sort of therapeutic practice it failed in some way then I would discard them. Um, but sort of doing the research awareness I found that … I could examine parts of my practice because, you know, I've been socialised into doing that and that was part of the norm of being a nurse.'*

So, research-based practice can break established, socialised habits passed on through the community of practice. These practices become established because:

> *'Historically its always been done that way and I suppose to challenge those things as a student is quite daunting. Just to stand up and say, "Just a minute, do you know why?" You know, to get a scornful glance passed your way. You just do it because they know, they're qualified nurses and they know that this is good and they know why they do it, so I'll just do it.'*

This constant development and learning shows that the practices of established masters are not always best; they can be learned and reproduced in a routine and unthinking way. Research-based practice can lead to questioning these routines and, by changing practices, can lead to a change in the community of practice as a whole. However, taking from research or theoretical models is more often than not done in an eclectic way, using the elements found to be effective in practice and discarding the rest. This also applies to models of nursing care. As seen below, nurses can be made to critically reflect upon their practices through programmes of education or by learning from students. However, the knowledge is put into practice in an eclectic way:

> **Interviewee:** *'I've had some um … very keen and very eager P2K students and I've thought "why don't you piss off now, I've had enough of you!" … and every other word out of their mouth is you know and why, and what and how and when, but in a way that sort of is what keeps you on your toes anyway and you think yeah um … With the health promotion module I did, I don't think up until that point I had ever really examined, you know what sort of model I subscribed to and neither did what model the patients subscribed to enter into the equation.'*
>
> **Interviewer:** *'What in terms of medical models?'*
>
> **Interviewee:** *'Yeah, yeah and … I mean not that I subscribe to any particular model mine is sort of hotchpotch, eclectic, sort of bits and pieces of all but I you know that hadn't been a question that I'd asked before and it was only through doing that bit of the diploma and examining, you know, what I think of health and ill health and where did those ideas sort of come from and which model best fits what it is that I do that I realised that there wasn't any one particular model that did.'*

This quote illustrates that not all knowledge is based on practical experience and that nurses pick up vital extra skills through programmes of education, enabling them to do their

jobs more effectively. When it was suggested to a nurse in A&E that most of the skills of nurses in the department seemed to be picked up through practice, we were corrected:

> **Interviewee:** *'Oh no I think you have got it wrong there, because er ... about 90% of the nurses in this department have been on an A&E course, and the ENB 199 course and have a great depth of knowledge in the basics of A&E nursing. Anatomy, physiology you know basic treatment of patients and advanced treatment of patients.'*
>
> **Interviewer:** *'This is like through the advanced trauma life support.'*
>
> **Interviewee:** *'Cardiac life support training, Drug and alcohol courses. They are not all academic courses. One of the best courses we do here is the drug and alcohol abuse course.'*

However, as seen in Chapter 6, deepening knowledge and maintaining and improving skills are not the only benefits from programmes of education. Nurses also establish networks with other nurses and other professionals that assist them in their work. In talking about a drug and alcohol programme, a nurse in A&E felt that:

> *'It's such an educational course for the nurses to go on because they are working with social workers, psychiatric nurses, police, probationer officers. And it's a whole mish mash of people who are there and the best thing about that is the networking that you do on this type of thing. You always know you can find someone who can give you some answer or help or assistance in a problem.'*

A local association of all A&E departments also provided support and information for its members and many experienced nurses found such networks useful. A number of functions are provided by such networks and by education: they give people a source of information from a range of different experiences and update people's skills. But these networks also provide support for nurses who can turn to other colleagues when in difficulty. In this sense, education helps to extend the community of practice beyond the immediate working environment. However, education has another important role in the maintenance and enhancement of skills: it gives people a basis from which to reflect upon and think critically about their practice. Furthermore, it provides ideas, information and research that are useful in creating better forms of practice. Education also provides a forum in which nurses can discuss practice and exchange ideas and experience.

As seen in Chapter 6, the community of practice in nursing and in education are often thought of as separate, divided by fundamental differences. Those involved in education, especially Project 2000 students, are often thought by experienced practitioners to be all theory with little practical skill. However, this chapter has shown the benefits that nurses of all levels of experience can draw from education, especially through the challenges of discussion with students and reading new research. Yet putting research into practice is not simply a matter of *application*, of reconceptualising it: rather, it is a matter of embodying knowledge, testing out theory and research by changing the form of one's own activities. In order to successfully maintain such practice it is also a matter of changing the community of practice, as nursing care is always delivered in the context of joint activities. In order for a nurse to be able to successfully change her or his own practice, therefore, she or he must change that of others too. But this raises again the question of the relationship between education and practice, which is addressed in Chapter 9.

CHAPTER 9 CONCLUSION AND DEVELOPMENTAL IMPLICATIONS

9.1 Introduction

The research team has been deeply impressed by the level of commitment evident in both the clinical and educational settings. Although the communities of practice in both settings revealed significant levels of stress that resulted from institutional forces defining their working environment, nurses were predominantly highly motivated. This engagement with the processes of nursing and nurse education was focused through a widely shared collective conception of 'the nurse', which provided an ideal type description of the caring nurse that was central to the negotiation of self with the working experience of being a nurse delivering clinical care, or educating future nurses. This conception of the caring nurse is central to the definition of nursing skills and their transmission through formal education. Delivering individualised holistic care is seen as transcending any simple application of technical competencies. The data presented above strongly echo Traynor's (1999) finding that a sense of personal commitment to the client and an incorporation of self into the role of nursing widely informs this shared collective vision.

As became apparent in Chapters 5 and 6, this shared vision of the nurse and nursing creates professional aspirations in relation to the quality of care that are not always easily attainable. The consequent negotiation of this mismatch of reality and expectation is one of the sources of stress that must be resolved through the operation of the coping strategies discussed in Chapter 7. Coping of course may be a necessity for the individual and possibly adaptive for a community of practice, but it may not necessarily be consistent with the best interests of the patient. Ossified practice as described by one nurse is at least partially the outcome of a collective routinisation of coping strategies within a community of practice. Shared critical reflection is thus an essential element of any nursing environment. To quote the Ace Project: 'Nurses and midwives who are both "knowledgeable doers" and "reflective practitioners" are found most often where research-based professional practice is institution-wide and all members of the community are engaged in a process of action, reflection, critique and further action' (Bedford et al., 1994: 3).

In examining the implications of this research one consistent theme, underpinning a range of suggestions, will be the centrality of the widest possible collective ownership of responsibility for guaranteeing standards of nursing and for initiating innovation in clinical practice and nurse education.

The concept of the community of practice has proved a robust analytic tool in revealing the processes operating in the delivery of nursing care, and in nurse education. The institutional and subjective axes defining the very particular nature of each community of practice have been revealed through the data. Consequently, communities of practice have emerged as highly complex environments shaped by multiple interacting variables. Yet one common theme which could be detected across the whole range encountered in this study was the experience of fragmentation.

As was revealed in Chapter 5 the cross pressures of patient need and limited resources engendered conditions in which planned control of the nursing environment was fraught, with nurses subject to the competing demands of several clients, their significant others and other professionals. This fragmentation of the clinical setting has its roots in the processes of change outlined in Chapter 2 and the immediate impact of the mismatch of demand and resources operating within the NHS. The multiple roles and demands experienced by the individual nurse has consequences described by one nurse as making nursing *'a process of successive interruptions'*. Each task is interrupted by a demand for the nurse to fulfil another function. However, this new function is then itself interrupted.

In such circumstances it is not unreasonable that much of the *modus operandi* operating in any community of practice had developed as a strategy of damage limitation; of seeking to 'ring-fence' their area of practice from the dislocation apparent in the system as a whole. Personal commitment and motivation were both a necessary prerequisite for the long-term viability of these strategies. And, ironically, commitment and motivation were also a continuing product of the success of these strategies.

But as both Chapter 5 and Chapter 6 demonstrated, sustaining a viable operating community of clinical practice involves a necessary degree of pragmatism in establishing priorities. Commitment to the client, personal professional development, mentoring or assessing students, and management functions are experienced as competing activities. As nurses on post-registration programmes in Chapter 6 indicated patient care, personal development and contributing to a lively learning environment in the clinical setting is far from the seamless thread of activity suggested in policy documents. Indeed the immediate pressure that makes the delivery of patient care such a fraught activity is additionally making clinical settings poorly equipped to provide an adequate learning environment for students. For example, Gerrish et al. (1997: 4) in their analysis of assessment of practice reported that: *'There was widespread recognition of the investment that was needed to prepare and support practice assessors and the resource intensive nature of this requirement.'*

At present the fragmentation, and hierarchical prioritisation of roles within the clinical setting is a severe challenge to the construction of an environment that can efficiently fuse clinical care with nurse education, or even theory with practice.

Fragmentation of purpose and of practice was also evident in the analysis of the educational setting. Modularisation had created a perception of staff responsibility for their own modules that had diffused responsibility for the whole curriculum at pre-registration level. This fragmentation of the curriculum was exacerbated by the transformation of lecturers' tutorial functions. Whereas previously they had acquired personal tutees on arrival in the school, and followed them through the programme, now this relationship was time-limited. Students in this system are the only persons capable of knowing and integrating the whole curriculum, and yet they have no stable tutorial relationship to aid them in this.

When the integration of the learning experience across the educational and clinical settings were tracked it became clear that in many instances the role of the link-lecturer was not adequate to bridge the two contexts in order to promote a coherent shared learning environment. In some instances the number of clinical sites identified with a lecturer made their efficient functioning virtually impossible. The competing demands of teaching, administration and research were further impediments to fully embracing this role for many. In this their experience was comparable to that reported by Day et al. (1998: 2) who in examining the role of the teacher/lecturer in practice observed that: *'There was agreement between all that issues related to lack of clarity in role definitions/terms of employment/workload pressure/numbers of practice areas allocated to each lecturer and lack of managerial and financial support were moderate or major deterrents to the practice role.'*

The evidence presented above would certainly offer no basis for disagreeing with that view. Indeed the links between the educational institution and clinical sites seemed reminiscent of those found by Gerrish et al. (1996), in their review of a number of institutions, where they were characterised by a minimal adequacy of communication. In essence where the system operates with no reported problems it is deemed adequate. But given the many pressures on staff of both institutions the potential for collusion in agreeing the definition of adequacy are considerable. There is a real fragmentation of communication between the educational and clinical sites which is not conducive to sustaining a meaningfully shared ownership of the learning environment of student nurses. This is critical to both a shared ownership of the theoretical curriculum and of the process of assessment: *'To ensure assessment which looks at theory and practice at one and the same time, mechanisms should be introduced to facilitate regular*

dialogue between clinical assessors, and between clinical assessors and their approved education institution colleagues' (Bedford et al., 1994: 1).

These mechanisms must not merely exist as barely adequate means of containing problems but should be resourced appropriately to ensure shared ownership of the learning experience, rather than a formally shared responsibility. The presence of rich and multiple lines of communication between educational and clinical settings is imperative if the integration of theory and practice is to be attainable in any meaningful way.

This need is underlined by the discussion of the acquisition and exercise of clinical judgement in Chapters 4 and 8. While current education seeks to instil in nurses an holistic understanding of the patient, with their social, psychological, physical and spiritual needs, it tends to neglect the nurse as an embodied person located in a community of practice. In other words the nurse as an holistic person tends to be absent from the process of nurse education and professional socialisation with the result that nurses are not always fully aware of how their whole being is part of the delivery of care. They are perhaps not always aware of the many levels and dimensions in which their knowledge exists and, therefore, of the effects of their practice upon patients.

The knowledge and capacities that nurses bring to practice exist on many levels: the level of conscious knowledge, practical yet taken-for-granted know-how, experience, emotional sense and intuition. Skills and capacities are partly based on professional training and yet many, such as the way a nurse deals with people, relates and communicates with them, are founded on personal ways of being developed in everyday life. This multi-levelled nature of knowledge and practice needs to be reflected in the curriculum at all levels of nurse education so that nurses may develop richer and more insightful forms of reflective practice.

This will involve keeping an emphasis on research-based practice and scientific forms of knowing. However, at the same time, the educational process must legitimate those other knowledges and capacities that play such a vital role, such as the use of emotion and the self, and the importance of experience and intuition in good quality nursing. In this regard the importance of emotional attunement in nursing and the centrality of communication and interpretation of the patient and the situation is stressed.

While it is often stated that such skills cannot be learned, along with intuition, nurse education and practice experience can build on and strengthen capacities that students already possess. For example, Chapter 8 has shown the importance of experience and how this develops the use of intuition in clinical decision-making. Intuition is an holistic form of understanding that brings together many aspects of a situation so that the nurse can better understand the whole. While intuition may not be learned in any formal way, intuitive judgement is certainly developed through practical or informal learning. However, formal education can play a part in this by recognising and emphasising the importance of intuition so that it becomes part of the nurse's reflective practice. Yet in order to do this the quality of interpersonal knowledge and engagement between student and tutor, mentor and assessor would require a qualitative transformation of these relationships beyond the norm revealed here. Quality time and continuity of contact are critical in facilitating such shared learning.

Good communication and interpretation skills can be built upon, facilitated and encouraged in the educational and practice contexts, and their importance can be emphasised for students so that they can build them into their own reflective practice. Certainly, communication and interpretation are more important in nursing today, where practice is a complex process involving building relationships between different professionals, as well as with patients and their significant others. The significance of these skills was underlined in Chapter 6 where confidence in one's nursing skills was explicitly linked with an ability to be assertive in ensuring the nurse's voice was appropriately heard in multiprofessional and inter-agency working. An important element in nurse education is enabling nurses to comprehend *how* they know as well as *what* they know, for the fusion of these forms of knowledge provides

a basis for their confidence in their professional skills, and forms the ability to communicate this knowledge to others.

It has been argued, particularly in Chapters 4 and 8, that the overly cognitive view of knowledge and practice found within nurse education needs challenging. There is a need to get away from the view that nursing models are learned in a disembodied, purely intellectual way, then superimposed upon the activities in the practice setting. Rather, knowledge must be put into embodied practice and this involves changing not only one's own practice but also that of the whole community. It would be impossible for a nurse to change her own practice while those around her were operating in a completely different fashion. A nurse's practice must always be to some degree 'in sync' with the rest of the community of practice. This again emphasises the need for a coherent shared ownership of the learning environment, spanning both educational and clinical settings. As the Ace Project argued in relation to the ownership of assessment of competencies: *'The greatest guarantee that assessment processes are both valid and reliable comes from their having been developed collaboratively so that documents, procedures and schedules reflect the needs of both practice and education'* (Bedford et al., 1994: 4).

However, the evidence presented above has vividly indicated the many institutional forces, operating in both the educational and clinical settings, which actively impede the meaningful development of such collaboration. For example, in Chapter 6 it was shown that even for nurses returning to their community of practice from a post-registration programme of education, it was not easy to carry their 'new knowledge' into the workplace. Thus a valued, and relatively privileged, means of linking theory and practice is undermined by circumstances in the workplace. Nor are educational institutions optimally placed to invest in building multi-layered and continuous links to practice. The functions of the link-lecturer were revealed to be in many instances seriously eroded, and the conditions of employment of lecturers within a university context were not conducive to their being enabled to sustain their own clinical practice. The fact that resource restraints within higher education make this a widespread reality within nurse education cannot make it acceptable. As Day et al. (1998: 3) concluded:

> *'The research revealed that failure to actively manage the practice role of lecturers is having an adverse impact on the quality of student learning and the development of the practice learning environment. It is also having a detrimental effect on the ability of lecturers to:*
>
> - *establish and maintain their clinical credibility;*
> - *support the continuous improvement of clinical practice;*
> - *further the development of practice-based research.'*

The case study material reported here reaffirm that conclusion. The multi-layered channels of communication, the overlapping flow of staff, and a resource base that guarantees an ability to realistically execute the agreed job descriptions that would be essential to sustaining 'the widest possible collective ownership of responsibility' for nursing and nurse education are widely absent in the contemporary situation.

This research has indicated the commitment and motivation of individual nurses. However, the picture that has emerged is of communities of practice in which nurses are striving to make the system work despite itself, rather than seeking to fine tune a working system. The data clearly suggest that in clinical settings, given the current under-resourcing of nursing, one of the impacts of over-stretched communities of practice is the de-skilling of highly competent nurses. Thus in some instances inadequate care results not from the absence of appropriate nursing skills, but from their suppression within the community of practice. Consequently an ambition for the improvement of clinical practice must be the promotion of communities of practice that facilitate the optimum expression of individual nursing skills in a shared working environment. This cannot be achieved without a significant increase in the resource base of the NHS.

Equally in the educational context the fragmentation of the learning experience, both within the university and in its linkage to clinical settings, and the consequent diffusion of responsibility for the ownership of the curriculum is urgently in need of remedy. The potential rift between theory and practice is exacerbated by the current circumstances within nurse education. As current complementary Board research, cited here, has indicated there is no shortage of insight into the ways in which this situation may be addressed. This research, however, has demonstrated the continuing failure to grant the resources that will allow the necessary policy innovations to be effectively implemented. In sketching out the implications of the research in the following section the researchers wish to emphasise their compatibility with other research and policy documents. The research reported here indicates a regrettable inertia in nurse education, where major institutional transformations over the last 10 years or so have produced a system that could promote coherence and collective responsibility for shared learning environments, but which palpably has not effectively done so.

9.2 Developmental implications of the research

In summarising the implications of this research in relation to each point the background issues emerging from the analysis are pointed out before specific implications are drawn from the analysis.

9.2.1 Linking the educational and clinical settings: integrating theory and practice

As was revealed in Chapters 5 and 6, fragmentation of the working process has become a consistent feature of delivering nursing care and of nurse education. This contributes to an erosion of the possibility of shared ownership of educational experience. In addition, changes in the structuring of the NHS outlined in Chapter 2 and the stretched resources in both the clinical and educational settings (Chapters 5 and 6) directly impinge upon the possibility of open, rich and adequate lines of communication between those working in the two settings. In particular, while there was considerable variation in practice, Chapter 5 demonstrated the significant resource restraints which limited the adequate operation of the role of the link tutor. The difficulty of sustaining a shared ownership of the learning environment across the clinical and educational settings is a recurrent theme of the analysis developed through this research.

9.2.1.1 Background issues

All clinical staff should understand their role in the collective ownership of the educational experience. As stated in *Making a Difference* (DoH 1999: 27): *'Every practitioner shares responsibility to support and teach the next generation of nurses and midwives'.*

There must be a collective ownership of the whole curriculum so that all modules are seen in inter-relation, not as free standing entities. Educational and clinical staff must co-operate in developing a shared understanding of how to engage a student in the learning environment within the clinical community of practice.

Any new system of educating nurses must be underpinned by stronger and more effective working relationships between the NHS and universities (DoH, 1999) and, as a complement to this, each clinical placement should be understood as a community of practice and be enabled to be sufficiently reflexive in order to understand their distinctive characteristics and engage with this explicitly in constructing the learning environment.

Implications

- Each clinical placement must have a link tutor responsible for developing the shared learning environment. This to include clinical co-supervision *in situ*. This link tutor could act as the accountable individual who liaises between universities and health care providers in terms of staff and student support, developing learning outcomes, and delivering and monitoring learning contracts (UKCC, 1999).

- Clinical supervision of all staff must be not only a formal requirement in all practice settings but also a de facto reality.

9.2.2 The mentor and assessor roles

The context of delivering nursing care within the cross-cutting demands of the multiple clinical responsibilities operating in specific communities of practice was capable of impacting negatively upon the role of the mentor. In addition it is possible that clinical staff do not experience sufficient managerial support in sustaining their professional development, and mentors and assessors may feel professionally exposed and under-resourced in seeking to fulfil these roles. Coupled with the wider issues of the fragile links between the clinical and educational settings there is clearly a need to address the preparation and support available for mentors and assessors.

9.2.2.1 Background issues

Mentors and assessors should have:

- familiarity with the current curriculum of students on placement
- explicit information on each student's current developmental stage within that curriculum. (a copy of a continuous record of achievement)
- an explicit statement of the expected learning outcomes of the placement.

Feedback should be open and multi-directional, with communication taking place between all the following participants:

- the student
- the mentor
- the tutor
- the link lecturer
- the assessor.

This feedback should be formalised, in line with recommendation 28 of *Fitness for Practice* (UKCC, 1999).

Implication

- The mentor and assessor functions should be formally factored into the clinical workload; funding should be available to facilitate this.

9.2.3 The personal tutor in the educational context

British universities have in the last decade developed a distinctive economic and managerial profile that has had widespread implications for the working environment of educational staff. In particular, modularisation and semesterisation have had significant consequences for the structuring of the learning environment and have contributed to the fragmentation of the learning experience. One critical aspect of this process is the potential undermining of a sustained and rich relationship between student and tutor. Given the model of knowledge and learning outlined in Chapter 4 and developed throughout this text, it is apparent that quality time and continuity of contact are critical to facilitating shared learning.

9.2.3.1 Background issues

Since student nurses within a university setting experience the same cultural and social changes, and personal growth, as other students they have a need of, and right to, a personal tutor. Student nurses effectively change jobs a number of times in three years as they enter different communities of practice; consequently they need someone who is aware of their developmental trajectory.

Acquiring clinical judgement skills and learning coping strategies is highly personal and may include intense emotional experiences and traumatic personal development, and student nurses therefore need a continuous tutorial relationship that allows for the building of trust and openness.

It is apparent that staff in nurse education value extended personal tutorial relations as intrinsic to professional education, feedback on the impact of the educational process and as a source of personal job satisfaction.

Implication

- Each student should have a personal tutor who follows them through their professional development within the course of their education.

9.2.4 The clinical experience of nurse educators in the university system

The many stresses operating in the working environment of nurse educators have been mentioned above. In bridging the shared ownership of the learning environment between the educational and clinical settings, the personal clinical competence of university-based staff is relevant to both shared ownership of the learning environment and to the perceived legitimacy of the lecturer's expertise. Lack of familiarity with and competence in the nursing skills relevant to a specific community of practice may have serious implications for the success of attempts to bridge the educational and clinical settings. In this study, at both pre- and post-registration levels, some lecturers were found with only limited personal current clinical experience. Where this exists it is both professionally threatening to the individual lecturer and a potential hindrance to a collaborative ownership of the learning process.

9.2.4.1 Background issues

Nurse educators' clinical skills and knowledge of practice settings must be kept up to date because:

- they must prepare students for clinical practice and draw upon the students' experiential learning as they progress through the curriculum
- they must have an understanding of the community of practice defining each placement and of how it shapes the learning environment
- they are central to facilitating an integration of theory with practice
- they should have credibility with students and clinicians.

Implication

- Recurrent clinical experience must be formally factored into the workload of nurse educators, and honorary contracts issued.

9.2.5 The phasing and structuring of student placements

The cumulative picture of clinical practice and nurse socialisation that develops through Chapters 5-8 underlines the importance of distinctive communities of practice for framing learning and nursing practice. Through Chapters 5-7 it becomes apparent that student nurses are currently fitted into these communities in ways that may not readily facilitate their optimal functioning. The need to adequately prepare students for entry into practice is reciprocally balanced by a need to allow for existentially meaningful participation within communities of practice. The model of knowledge and learning outlined in Chapter 4 and developed in Chapter 8 emphasises the importance of guaranteeing an adequate basis for existential learning within specific communities of practice.

9.2.5.1 Background issues

Student nurses need to develop their skill base experientially. This process of professional socialisation and identity formation takes place within distinct communities of practice, so placements must be long enough to enable students to become accepted participants within these communities. Student status currently effectively excludes students from full participation in the routine of communities of practice, including working whole shifts, weekends and nights, their full understanding of communities of practice and their opportunities to develop an understanding of leadership and managerial skill are impaired. Frequently they are the only student in a community of practice, and therefore lack peer support that could aid reflective learning; and a corpus of students, mentors and tutors is not developed in, and around, the community of practice to facilitate a collective ownership of the educational environment.

Implications

- After an initial intense educational induction period clinical placements should be in long continuous blocks.
- Students should be integrated into the full working routine of a community of practice.
- Student nurses should be allocated to clinical placements with a minimum of two students to each community of practice.

9.2.6 Preparation for the management of stress

Chapter 7 provides extensive insight into the sources of stress and the mechanisms of coping with stress in nursing practice. It became apparent in that analysis that mechanisms for managing stress are collectively negotiated within distinct communities of practice. These mechanisms may be ultimately dysfunctional, and not always easily transferable. Consequently, the preparation of students to recognise and understand such coping mechanisms is an important task within nurse education.

9.2.6.1 Background issues

All student nurses should be enabled to develop an understanding of what forms of coping works for them, and of the management of *their* coping within the institutionalised modes of coping operating within any particular community of practice. It follows, therefore, that students should be taught about stress, emotion and coping strategies *before* starting on clinical placements; consequently they should be provided with a thumbnail sketch of the stressors and predominant coping strategies existing within any community of practice prior to their entering it on placement. This will then enable students to understand the positive outcomes that may arise from distressing emotional experiences and through reflection be able to resist *unthinkingly* acquiring modes of coping that are normative, and not necessarily entirely clinically helpful, within particular communities of practice.

Implications

- An explicit learning objective within the first clinical placement should be development of an ability to recognise and reflect upon stress factors in the workplace and the management of stress and emotion. These skills could be fostered by the uses of experiential and problem based learning.
- The taught curriculum prior to this placement must prepare the student for this task.
- Within the curriculum students should be taught the history and sociology of nursing, particularly in relation to the power relations and dynamics between professionals, patients and the public, so that they may learn to recognise and reflect upon these dynamics and appropriately negotiate hierarchies of power through communication.

9.2.7 Nurse education within higher education

The institutional axis determining the nature of specific communities of practice has been confirmed as a key variable in shaping nursing education and practice. As outlined in Chapters 2 and 6 developments in nurse education and their location within the British university system have powerful institutional dynamics which are shaped by political processes that transcend the immediate power and responsibility of individual nurses. Universities as structures have powers and responsibilities that must be recognised and employed at an institutional level.

9.2.7.1 Background issues

Changes in university funding and the structuring of higher education in England have resulted in nurse educators being in a particularly stressed situation given the competing demands of teaching, tutoring, administration, research, clinical liaison and clinical practice. Consequently there is evidence of a fragmentation of the learning experience within the educational setting. Additionally, faced with the production demands of the RAE, nurse educators may be particularly disadvantaged in developing their research activity given the multiple demands upon their time. Within this context it is apparent that post-registration programmes are particularly valuable contributions to the development of nursing care.

Implications

- University administration at the highest level must recognise these multiple competing demands and negotiate realistic job descriptions that create the essential space for the innovations recommended above.
- Senior programme managers must be explicitly charged with the responsibility for ensuring a collective ownership of the whole learning experience of students.
- The research activity of nurse educators should be carefully nurtured through explicit developmental programmes.
- Much valuable research could pursue co-operative inter-agency collaboration focused upon the clinical responsibilities of teaching staff.
- The current success of post registration courses should not be taken for granted. Their current strengths should be built upon by a positive review of their fit with educational needs and the possibility of innovative new partnerships.

9.3 From implications to implementation

None of the recommendations above seem likely to be seen in principle as outrageously radical, and the rationale underlying each can be identified within the analyses offered in the preceding chapters. Yet of course, within the politics of the NHS in general, and nurse education in particular, there will be ample grounds for finding them highly problematic. Much of what is proposed is premised upon a reassertion of existing beliefs and formal expectations relating to nursing practice and education. For example, the implications in Sections 9.3.1, 9.3.2 and 9.3.4 centre upon the key place of clinical experience in nurse education, and the essential role of clinical supervision within that process. While there may be issues of professional statuses and territorial boundaries to be negotiated in thinking through and implementing these suggestions, the fundamental objection will be cost. Realistically recognising in practice the implications of guaranteeing the adequate clinical supervision of all staff and students requires a radical restructuring, not only of job descriptions, but of workloads. This must involve additional costs.

Similarly although the implementation of the implication in Section 9.3.3 regarding the role of the personal tutor can be conceived as merely an administrative reallocation of tutorial resources over a three-year period, the implementation of the spirit of this recommendation must generate an additional demand for tutorial time. Here too there must

be inevitable cost implications. And any meaningful response guaranteeing the clinical practice of nurse educators must, in the majority of institutions, require a redefinition of the job description and the normative working routine. In essence more staff will be needed. Yet much of the change implicit in the implications in Sections 9.3.5, 9.3.6 and 9.3.7 need not demand additional continuing new resources. However, in an educational system already under strain any innovation must in the short term be perceived as an additional burden.

Nurse education has been through a somewhat traumatic process of continuous change, and although robustly active in its recent location within higher education, this research has underlined the acknowledged pressures under which nurse educators and clinicians currently work. Equally this research has revealed the almost surprising level of commitment to high quality nursing care within the profession. The challenges confronting nursing education cannot be met by appeals for one more superhuman effort from lecturers. This research has revealed that it is not the subjective aspirations of nurse educators, clinicians and students that present the fundamental challenge to nursing care. Again and again the forces present in the institutional axes of nursing education and practice are revealed as setting the limits of feasible attainment. Thus the implications arising from this research inevitably constitute a challenge to the current collusive under-funding of nursing care and nursing education. Those who set the goals for nursing standards must be prepared to demonstrate that they have willed the means.

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RESEARCHING PROFESSIONAL EDUCATION

A series from the English National Board for Nursing, Midwifery and Health Visiting

Nurse Education and Communities of Practice

Ian Burkitt
Charles Husband
Jennifer MacKenzie
Alison Torn
with Rosemary Crow

This report, in the Board's series *Researching Professional Education*, has been published to make Board-commissioned research readily available to policy makers, practitioners, researchers and educationalists.

Learning to become a nurse is always situated within particular communities of practice. Becoming a nurse involves more than the learning of a body of knowledge and a range of skills. It involves a complex process of socialisation to develop a professional whose very identity is constructed and maintained within nursing practice.

This research is a valuable aid to our understanding of the emotional and intellectual process of learning within practice.

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research

Clinical Judgement and Nurse Education: Nursing Identities and Communities of Practice

Research Team Members:

Dr. Ian Burkitt, University of Bradford

Professor Charles Husband, University of Bradford

Ms. Jennifer MacKenzie, University of Bradford

Ms. Alison Torn, University of Bradford

with:

Professor Rosemary Crow, University of Surrey

Steering Group:

Professor Ian Stronach, (Chair) Manchester Metropolitan University

Professor Rosemary Crow, University of Surrey

Dr. Sonia Crow, Assistant Director (R&D), English National Board

Dr. Colin Lago, University of Sheffield

Ms. Cathy Renouf, Education Officer, English National Board

Dr. Anne Williams, University of Swansea

English National Board for Nursing, Midwifery and Health Visiting

Victory House
170 Tottenham Court Road
London W1T 7HA

Telephone: 020 7388 3131
Fax: 020 7383 4031

Abstract

This project was commissioned by the English National Board as an evaluation of the cognitive and affective processes developed in the educational preparation of nurses to deliver individualized and holistic care. Initial pilot work very strongly demonstrated that the terms 'cognition' and 'affect' were seldom employed and only ambiguously understood in nursing education and practice. However, our task was to understand how knowledge and skill are actually developed through education and practice. The concept of 'community of practice' proved a powerful tool in aiding our understanding of how the learning of nursing skills and the development of a body of knowledge about nursing care is not simply an intellectual process, but also a practical one. Participant observation of nurses in a range of clinical settings and detailed interviews with staff and students in a University Department of Nursing provided rich and relevant data. The powerful processes of nurse socialization that create a strong core identity of the 'good nurse' proved to be central to understanding the acquisition, use and protection of nursing skills. The core findings, methodology and wide ranging implications of this research are sketched overleaf.

Main Findings

The aim of our research became not simply to study the learning of skills, whether cognitive or affective, but rather to try to trace the construction of an identity – that of the professional nurse. We sought to map and understand the factors that feed into this process. Ongoing clinical practice in specific areas of nursing provide a key site where skills are acquired, rehearsed and given value. The unique physical, staffing and resource characteristics of each setting provide the context in which communities of practice (Lave and Wenger, 1991) must operate and be sustained.

Departments of Nursing, operating in the context of University institutional routines, are also fundamental to the transmission of nursing skills and nursing values. Staff in Universities also work under constraints and often with quite specific specialist identities.

We viewed both the clinical practice settings and the Department of Nursing as communities of practice. That is, as a group of co-participants involved in joint activities (the delivery of nursing care and the education of students) that reproduce the community over time by the gradual induction of new members. Becoming an expert member of the community involves the student in situated learning, a process in which they are co-participants in the community of practice from the very beginning, albeit on the periphery. This means that the novice starts with limited responsibilities for a clearly defined and designated set of activities. These responsibilities and designated practices increase and expand along with the development of the student's expertise as a nurse.

In our report we therefore found that learning to become a nurse is always situated within particular communities of practice. To learn in such contexts, both in clinical and educational settings, is not simply to master a range of intellectual concepts, but also to learn through embodied performances that involve engagement and interaction within the community of practice.

Becoming a nurse involves more than the learning of a body of knowledge and a range of skills. It involves becoming a *nurse*, a certain type of person whose very identity is constructed and maintained through nursing practice.

However, in becoming nurses we have identified two problems currently faced by students. Firstly, they are located in two distinct communities of practice, the University Department of Nursing and their various clinical placements, and the link between these two communities is not always developed in ways that will help the student. Secondly, as Davies (1995) has pointed out, nursing is an activity that often resists clear definition as it is made up of many different tasks involving different forms of skill and knowledge. Students are not always prepared for this as the different levels of practice, skill and knowledge are not always spelt out clearly for them in the curriculum.

In this respect we have also attempted to identify the different levels of knowledge and capacities that are involved in nursing practice, including practical yet taken-for-granted know-how, consciously reflective knowledge, experience, emotional sense and intuition. Skills and capacities in nursing are partly based on professional training and socialization, yet many, such as the way the nurse relates to others, are founded on personal ways of being developed in everyday life. This multi-levelled nature of knowledge and practice needs to be reflected in the curriculum of nurse education so that nurses may develop richer and more insightful forms of

reflective practice.

Therefore, within this study it has been evident that whilst current education seeks to instil in nurses a holistic understanding of the patient, it tends to neglect the nurse as an embodied person (Burkitt, 1999) located in a community of practice. Intuition was revealed as an example of why we need a holistic understanding of the nurse, for this is a form of knowing that involves synthesis of a nurse's experience and knowledge, bringing together many different aspects of a situation and different levels of practice.

Nurse education needs to enable nurses to understand how they know as well as what they know. It is the fusion of these forms of knowledge that provides a basis for their confidence in their professional skills.

The implications of this research include:

- Linking the educational and clinical settings by helping clinical staff to understand their collective role in the educational experience and encouraging University staff to collectively own the whole curriculum.
- Making sure that each clinical placement has a link tutor responsible for developing the shared learning environment.
- Enhancing the Mentor and Assessor functions, which should be formally factored into the clinical workload, and funding should be found to facilitate this.
- Health-care providers and Universities should enable, support and resource time in education for clinicians and time in practice for educators.
- Student placements should be in long continuous blocks so that they can become more fully integrated into the full working routine of a community of practice.
- Students need more preparation for the management of stress.

This last implication was linked to another of our findings. This was that in both educational and clinical settings limited resources, physical constraints of time and space and external managerial priorities impact negatively upon the nurses' and educators' ability to work to their own professional standards.

At the core of nursing commitment and professional self-regard there is a strong shared identity. This inclusive identity of 'nurse' has at its heart a commitment to caring and to delivering holistic individualised care. Caring, compassion and empathy were regarded as essential characteristics of this generic nurse identity.

Suffused throughout the community of nursing practice there is a shared belief in a personal engagement with the patient. Emotional labour may be a feature of such nursing, but it is seen as a valued challenge rather than a burden.

However, a fundamental source of stress for nurses exists in the mismatch between this shared image of 'the good nurse' and the inability to deliver the quality of care they would wish to.

Communities of practice, in distinct settings, were revealed as highly complex environments shaped by multiple interacting variables. Yet, one common theme, detected across the whole range of settings in the study, was the experience of fragmentation.

The multiple roles and multiple demands experienced by nurses in clinical settings was aptly described as making nursing "a process of successive interruptions". Each

task that is started is interrupted by a demand for the nurse to fulfil another function.

Fragmentation of purpose and of practice was also amply evident in the educational setting. The introduction of modularisation had, in particular, fragmented ownership of the whole curriculum and severed a continuous link with tutees.

Additionally, there is a real fragmentation of communication between the educational and clinical sites, which is not consistent with sustaining a meaningfully shared ownership of the learning environment of student nurses.

Specialist identities within the generic community of nursing provide strong in-group norms and powerful collective identities. Whether it is Accident and Emergency, Burns or Palliative Care these 'specialist' communities of practice tend to have distinctive working environments. The specialist identity incorporates shared norms for coping with these distinctive pressures.

The report identifies many of the coping strategies used by clinical staff and educators to help them survive this experience of fragmentation. For clinical staff this is often reflected in techniques for the management of emotion, especially in relation to the patients.

Also, mobility between specialist areas of practice can be seen to contain a strong element of moving towards a better environment. Not necessarily an easier environment, but a context where the nurse will be enabled to deliver a quality of care that is consistent with the generic identity of 'the good nurse'.

All of this means that the delivery of nursing care and the exercise of clinical judgement currently takes place in fragmented contexts where nurses are striving to sustain professional identities through their practice.

Details about the Project

This two-year project was commissioned in 1997 by the English National Board for Nursing, Midwifery and Health Visiting. The project was a collaborative activity between the School of Applied Social Sciences and the School of Health at Bradford University.

The research will be of interest to all those concerned with the education of nurses and the delivery of health care. It focuses on the skills and knowledge acquired by nurses in actual current contexts of nursing practice and studies areas that generally have been under-researched. The picture that emerged from the data is of communities of practice where there is a high level of commitment among nurses in both the clinical and educational settings to core nursing values such as the holistic and individualized care of patients. However, the current context of fragmentation in both settings means that nurses are striving to make the system work despite itself.

For nurse managers, health planners, nurse educators and practitioners, this research has ample evidence-based implications to challenge the status quo and inform necessary innovation.

Method

Given the importance of the concept of 'communities of practice' in this research, an ethnographic and interpretative approach was employed. Ethnography has been defined as a 'portrait of a people' (Burns and Grove, 1993). This was exactly what this study aimed to provide. And not only a portrait, but also an analytical understanding of nursing practice and education set within its everyday context. Ethnography is a style of enquiry that enables the researcher to gain access to the meanings contained in a culture, which guide its members' behaviour. In this study, participant observation backed up by interviews was employed in the clinical settings. It was not a feasible option, nor necessarily appropriate in the educational setting, where extensive individual and focus group interviews provided a rich cross-referencing of the practices and culture in that setting.

Participant Observation and Critical Incident Interviews in Clinical and Community Settings

Two of the research team are qualified nurses, one in adult nursing and the other in mental health. This enabled them to join various communities of nursing practice as participating members. They played a full part in the activities of the community while their role as researchers and the purpose of the research was known to all.

In each setting the participant observer 'shadowed' specific identified staff. This gave focus to the observation and allowed for key instances in the day's practice to be reviewed with the nurse in a 'critical incident' interview. These interviews clarified the researcher's insight into the meanings the nurse brought to the incident. Twenty such detailed interviews were transcribed. The participant observers also wrote detailed field-notes about each location they observed. All the data from the

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participant observation of clinical sites was analysed by another member of the research team who was not involved in collecting the data. This, amongst other things, excluded from the analysis the participant observer's personal feelings about individual actors.

The Educational Setting – Individual Interviews and Focus Groups

Access was gained to a large multi-site School of Nursing. Lecturers were selected for interview in order to tap a broad range of expertise across the curriculum and in the administrative management of specialisms. Eighteen academic staff were interviewed and focus group interviews were conducted with students on seven different post-registration courses. Again, initial analysis of the material was carried out by members of the research team who had not been involved in the data collection.

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